Kidney Quality Improvement Partnership (KQuIP)

What can we learn from Transplant First?

Kerry Tomlinson
Rachel Gair

13th February 2020
The Kidney Quality Improvement Partnership (KQuIP) is the Quality Improvement infrastructure of the UK kidney community. It is active in 10 regions and nationally across the paediatric kidney community. It is a collaboration of 59 renal units working together on quality improvement.

KQuIP has 171 quality improvement leaders championing change in their kidney units. These leaders are supporting them to grow QI skills and embed QI in everyday kidney care. KQuIP has also supported 133 quality improvement leaders through tailored leadership training, which is key to sustainable change and improvement.

Leadership across all levels of kidney care is essential for sustainable change and improvement. KQuIP has engaged 8 regions in their QI project, launching regional events to help engage the wider community and stakeholders. The aim is to upskill the kidney workforce in QI, making it a key KQuIP objective.

KQuIP is part of The Renal Association, founded in 1950, and is supported by the British Renal Society, representing professional renal nurses.
# Transplant First – the national picture

<table>
<thead>
<tr>
<th>Region</th>
<th>Units</th>
<th>Implementation stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>Aintree, Royal Liverpool, Wirral, Manchester, Royal Preston, Salford</td>
<td></td>
</tr>
<tr>
<td>Thames Valley</td>
<td>Oxford Hospitals, Royal Berkshire Hospital</td>
<td>Collecting data and process mapping. Aim developed. Change ideas emerging. QI learning events scheduled.</td>
</tr>
<tr>
<td>South West</td>
<td>Gloucester, Cornwall, Bristol, Plymouth, Exeter, Dorset</td>
<td></td>
</tr>
<tr>
<td>South East</td>
<td>Brighton, Portsmouth, Canterbury</td>
<td>Collecting data and process mapping. Aim developed. QI learning events scheduled.</td>
</tr>
<tr>
<td>South London</td>
<td>Epsom and St Helier, Guys and St Thomas, Kings College, St Georges</td>
<td>18 week pathway. Data collection along this. IT access to referring hospitals/satellites. Hand held records. E-referral</td>
</tr>
</tbody>
</table>
Implementation – what we have learned

- Time and support is required for participants to understand and use the data collection tool
- Time is also required to engage teams and to include the right people in the team to drive improvements
- People are using ‘Transplant First’ in everyday language
- Participants are keen to network and share learning
- Achievement – multi-professional approach with the transplant coordinators driving/leading the project
- Data continues to be collected. Positive results include better access to clinics, better communications, etc
SUCCESSES

Implementing 18 week pathway and collecting data against it (recipient and donor)

Transplant dashboard commenced – regional data set

**Measuring** and intervening – one stop clinic, e-referrals, talk transplant @ 20/25

Collecting real time data that is meaningful, useful and owned by centre and region

Collaboration between transplant centres and referring centres (surgeons and nephrologists + MPT)

Patient involvement in QI
Challenges

Data collection – fragmented with lack of coordination (no one owning it)

18 week pathway – start/stop of clock

Making change happen – sharing findings internally and gaining full support for Tx First (creating theatre space)

Cardiology investigations – ? Need national lead on This

Engagement and understanding around QI – it isn’t just about project management and implementation (hard lesson to unlearn)
## Access to kidney transplantation for adults by transplant versus non-transplant centre

Patients treated at Tx renal centres were compared to those treated at non-Tx renal centres.

### Table 6.6

Odds of adult RRT patients being wait-listed within 2 years of RRT start and odds of wait-listed patients being transplanted within 2 years of wait-listing by Tx status of renal centre (cohort incident to RRT 01/01/2012–31/12/2014 and wait-listed by 31/12/2015), risk adjusted by age group, ethnicity, sex and primary renal disease, modelled with logistic regression

<table>
<thead>
<tr>
<th>Tx type</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odds of patients being wait-listed ( \leq 2 ) yrs in non-Tx centre</td>
<td>0.68</td>
<td>0.62–0.74</td>
</tr>
<tr>
<td>Odds of wait-listed patients receiving a Tx ( \leq 2 ) yrs in non-Tx centre</td>
<td>0.88</td>
<td>0.79–0.99</td>
</tr>
<tr>
<td>DBD</td>
<td>0.91–1.21</td>
<td></td>
</tr>
<tr>
<td>DCD</td>
<td>1.19–1.60</td>
<td></td>
</tr>
<tr>
<td>LKD</td>
<td>0.58–0.74</td>
<td></td>
</tr>
</tbody>
</table>

CI – confidence interval; DBD – donor after brain death; DCD – donor after circulatory death; LKD – living kidney donor; OR – odds ratio
Pre-emptive listing as a proportion of those listed

Figure 1.6  Adult pre-emptive listing rates by centre, registrations between 1 April 2013 and 31 March 2016
What have we learnt about interactions and pathways?
What are the common themes?
Focus on why referring and transplanting units are different
Focus on transplant listing
Won’t name and shame
I’m talking about barriers- there were many positives

As we go through- do these ring true to you? How might you address them in your Transplant Worksteam
Getting together

For many regions the KQUIP events are a new (welcomed) opportunity to work together especially for the non-doctor MDT members. Working together is very positive but tense relationships and hierarchy can creep in leaving things unsaid and too much said by others.  

- Transplant/referring units  
- Consultants/MDT  
- Surgeons/non-surgeons  

Can be disengagement

Suggested rules of engagement

Be open (even if you think you know the answer)

Be non-hierachical

If you are talking all the time stop and listen (particularly consultants)
Interactions and pathways

Usually identified the need to start further “upstream” in low clearance services
Often units are working with two transplant units with different requirements
2 step pathways cause delay
Handover points often go wrong and may have simple solutions
There can be surprisingly large numbers of visits (especially for donors) and complex pathways
Referring and transplanting unit nephrologists are treated differently
Assessment Guidelines

There is often a lack of them
Sometimes non-evidence based rigid requirements

- CPET
- BMI
- Dentist

Shifting goalposts and personal opinions mean that referring units are guessing what is needed
Referring units may give incomplete information
Common barrier themes: Clinical

Cardiology
- Resource cited but more likely pathways
- Non-uniform pathways not clear to referrers
- Difficult to obtain tests with no evidence base
- Starting assessment early enough
- Specialty opinions
- Decision making
- MDT friend or foe
- Delay in bidirectional communication
Common barrier themes: Resources

Ability to provide clinic capacity

Nursing time very strongly thought to be important
- ATTOM survey showed similar
- Difficulty defining transplant assessment nurse means studies haven’t shown link

Finance and commissioning
Bucking the trend: features where referring units performed better than transplant unit

Champion
Very close surgical interaction and clear pathways
Direct access to cardiology tests
Undertook a QI project
Systematic review of status
Continual eye on performance
Specialist nurses
Suggestions to units

Transplant units

- Treat referring centres as equals
- Have clear, unambiguous pathways and guidelines
- Don’t add non-evidence based or personal opinion barriers
- Use MDT wisely
- Devolve and support locally

Referral units

- Have a clinical champion and take responsibility
- Talk to other units in your region who are doing better
- Give transplanting unit information they need
- Give enough time/start early

Talk to each other
Transplant First Data Collection tool: Who

Developed during work in West Midlands with the Renal Registry

Thanks to

- Fiona Braddon
- Rapolas Kaselis
- Retha Steenkamp
- Ron Cullen
- West Midlands nurses, data people nephrologists and patients
- KQUIP team
Transplant First Data Collection tool: Why

“Real time” monitoring of performance (measurement for improvement)
Mini Route Cause analysis (RCA) when pre-emptive transplant listing was missed
When units used it actively it was very useful
- Identified barriers
- Promoted difficult conversations
- Provided feedback on performance

If you want to know more Webex https://meetings.webex.com/collabs/url/aov7N2-ixCQTpNd-W3oGLuZ6jXFNo7Y60VcpGzDSTRK00000
What the tool collects: performance at two time points in the patients journey

- Listed
- Unsuitable
- Missed (not documented or in workup)

Rolling 12 month percentage of incident transplant listed patients who were listed pre-emptively

Data made up in these graphs
### Dialysis starters: not acute starts, known to unit

<table>
<thead>
<tr>
<th>No</th>
<th>Status</th>
<th>Reason</th>
<th>Comment</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Active on list</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Suspended from list</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Documented as unsuitable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Working up or under discussion</td>
<td>Select Reason</td>
<td>If this is ticked, this field is required.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Working up or under discussion</td>
<td>Referred for Assessment when eGFR &lt; 15</td>
<td>Missed in peripheral clinic</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Working up or under discussion</td>
<td>Referred for assessment within 1 year of predicted date of reaching ESRF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Working up or under discussion</td>
<td>Patient DNA on at least 3 separate assessment Appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Working up or under discussion</td>
<td>Medically Complex</td>
<td>If this is ticked, this field is required.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Working up or under discussion</td>
<td>Delays in system</td>
<td>If this is ticked, this field is required.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>No documented decision</td>
<td>Unsuitable for transplant but NOT documented</td>
<td></td>
<td></td>
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</tbody>
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## Transplant First Data Collection tool: What did we learn

### Reason why patients at start of RRT were still in work up in the West Midlands

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late referral eGFR &lt;15</td>
<td>13 (10/79)</td>
</tr>
<tr>
<td>Late referral &lt;1yr from RRT</td>
<td>15 (12/79)</td>
</tr>
<tr>
<td>DNA</td>
<td>16 (13/79)</td>
</tr>
<tr>
<td>Delays</td>
<td>24 (16/79)</td>
</tr>
<tr>
<td>Complex</td>
<td>34 (27/79)</td>
</tr>
<tr>
<td>Unsuitable not documented</td>
<td>1 (1/79)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason Complex or delays</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay to transplant centre</td>
<td>4</td>
</tr>
<tr>
<td>Specialty opinions</td>
<td>6</td>
</tr>
<tr>
<td>Cardiology</td>
<td>6</td>
</tr>
<tr>
<td>Urology</td>
<td>4</td>
</tr>
<tr>
<td>Nephrectomy</td>
<td>4</td>
</tr>
<tr>
<td>Other delay</td>
<td>3</td>
</tr>
<tr>
<td>Other or non-specific</td>
<td>16</td>
</tr>
</tbody>
</table>
Transplant First: Thanks to everyone working to improve access to transplantation