Kidney Quality Improvement Partnership (KQuIP)

What can we learn from Transplant First ?

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The Kidney Quality Improvement Partnership

KQuIP

The Quality Improvement infrastructure of the UK kidney community

Active in **10** regions and nationally across the paediatric kidney community

59 renal units collaborating together on **quality improvement**

3 priority areas for improvement

- Access to Home Therapies
- Vascular Access
- Transplantation

171 quality improvement leaders are **championing** change in their kidney units.

KQuIP is **supporting** them to grow QI skills and embed QI in everyday kidney care.

133 quality improvement leaders have undergone **tailored leadership** training

Leadership across all levels of kidney care is key to **sustainable** change and improvement

8 regions launched their QI project with a regional event, helping **engage** the wider community and stakeholders

Quality improvement leaders have attended **18** training days

Upskilling the kidney workforce in QI is a key KQuIP objective.

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Transplant First – the national picture

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

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)

Transplant vs. renal centre

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

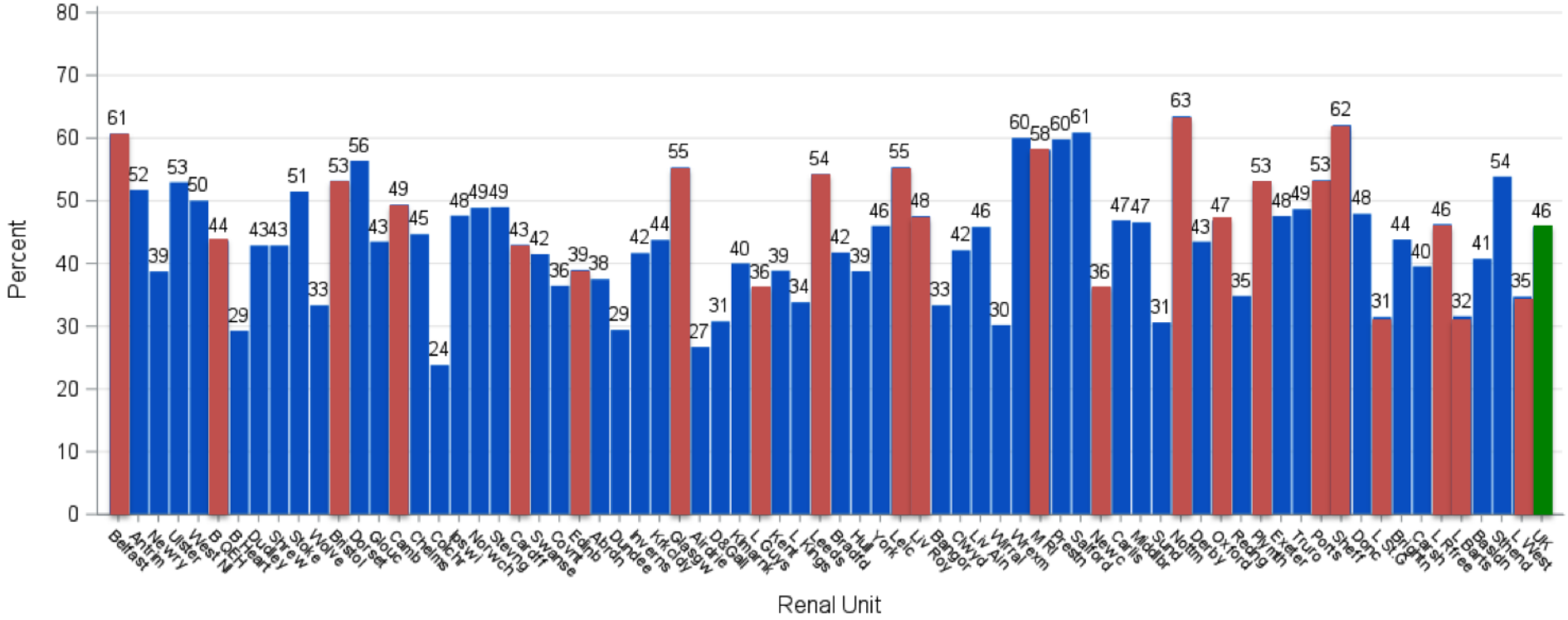
	Tx type	OR	95% CI
Odds of patients being wait-listed ⩽2 yrs in non-Tx centre		0.68	0.62–0.74
Odds of wait-listed patients receiving a Tx ⩽2 yrs in non-Tx centre	Any	0.88	0.79–0.99
	DBD	1.05	0.91–1.21
	DCD	1.38	1.19–1.60
	LKD	0.65	0.58–0.74

CI – confidence interval; DBD – donor after brain death; DCD – donor after circulatory death; LKD – living kidney donor; OR – odds ratio

GETTING IT RIGHT FIRST TIME

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



GETTING IT RIGHT FIRST TIME

Blood and Transplant

What have we learnt from working with regions on Transplant First

What have we learned 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 Workstream

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)

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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

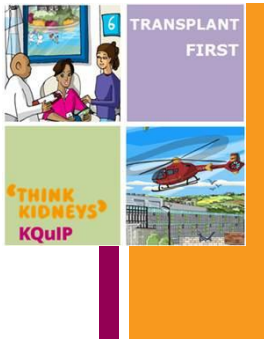
Ability to provide clinic capacity

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

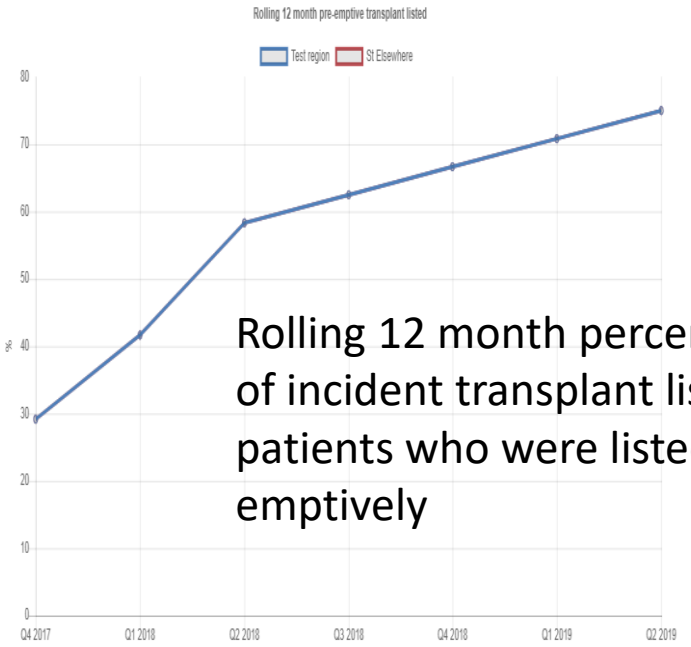
When units used it actively it was very useful

- Identified barriers
- Promoted difficult conversations
- Provided feedback on performance

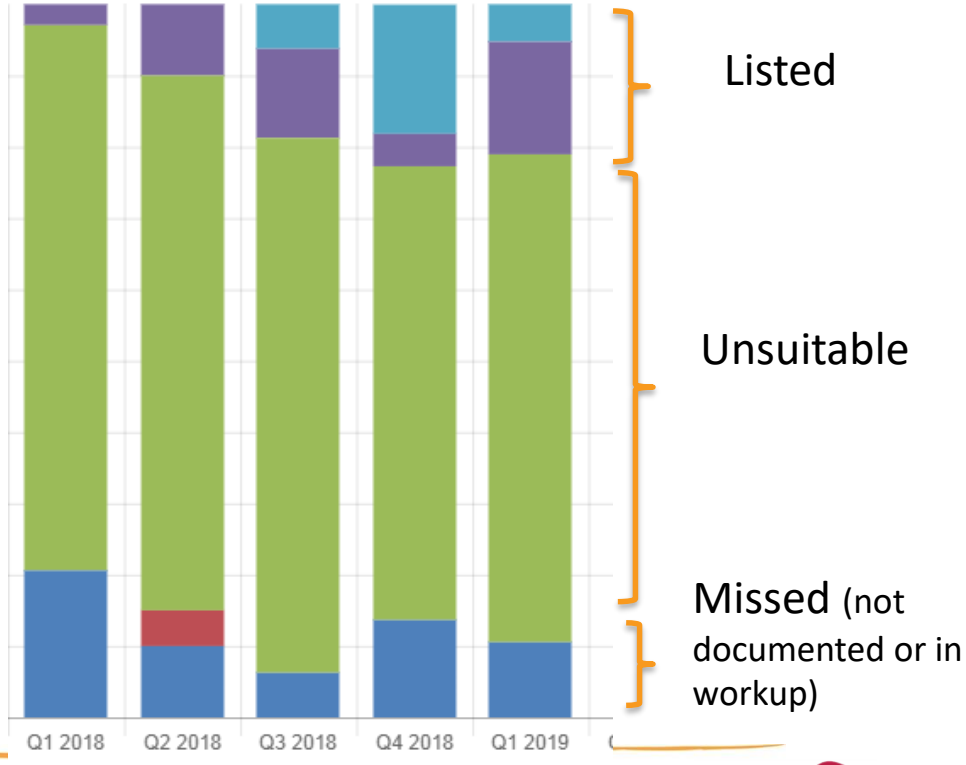
If you want to know more Webex https://meetings.webex.com/collabs/url/aov7N2-ixCQTpNd-W3oGLuZ6jXFNo7Y60VcpGzDSTRK00000

What the tool collects: performance at two time points in the patients journey

- Click to edit Master text styles
  - Second level

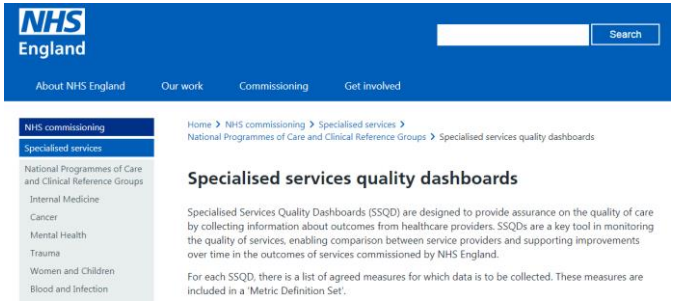


Rolling 12 month percentage of incident transplant listed patients who were listed pre-emptively



Data made up in these graphs

Dialysis starters: not acute starts, known to unit



Export data

No	Status ⓘ	Reason ⓘ	Comment	Actions
1	Active on list			
2	Suspended from list			
3	Documented as unsuitable			
4	Working up or under discussion	Select Reason This field is required.		
5	Working up or under discussion	Referred for Assessment when eGFR < 15	Missed in peripheral clinic	
6	Working up or under discussion	Referred for assessment within 1 year of predicted date of reaching ESRF		
7	Working up or under discussion	Patient DNA on at least 3 separate assessment Appointments		
8	Working up or under discussion	Medically Complex	This field is required.	
9	Working up or under discussion	Delays in system	This field is required.	
10	No documented decision	Unsuitable for transplant but NOT documented		

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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

Reason	%
Late referral eGFR <15	13 (10/79)
Late referral <1yr from RRT	15 (12/79)
DNA	16 (13/79)
Delays	24 (16/79)
Complex	34 (27/79)
Unsuitable not documented	1 (1/79)

Reason Complex or delays	Number
Delay to transplant centre	4
Specialty opinions	6
Cardiology	6
Urology	4
Nephrectomy	4
Other delay	3
Other or non-specific	16

Transplant First: Thanks to everyone working to improve access to transplantation

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