KQUiP/SLRCA Peer Assist Event

17th January 2020

Chair: Dr Rob Elias – SLRCA Clinical Lead

The work-stream co-chairs and multi-professional QI leads were invited to take part in an afternoon of Peer Assist. Each of work-stream co-chairs presented a few slides to the audience outlining the aims of the project and the achievements so far. They supported this with unit data highlighting the issues/problems, the current challenges and the priorities for the next 3 months.

The audience then acted as a critical friend to interrogate the information they had been given and ask questions to challenge the co-chairs and project QI leads to gain an understanding.

Objectives for the day:

- Each team to leave with the key message from the project to share with a wider audience (what is it you are addressing and how)
- Agree a measurable aim for each project to be delivered within a time frame
- An understanding of the QI role and how it collectively works across all projects
- Provide challenge, debate and solutions to the current blocks to change
- Teams to leave with clear actions and practical guidance on how to make progress

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Supportive Care Project

Attenders:

Katie Vinen – co-chair (Kings)	Kate Shepherd – Kings
Seema Shrivastava – co-chair (St Georges)	Marlene Johnson - StG
Sharon Frame – GSST	David Evans - StH
Sarah Watson – GSST	Heather Brown – GSST

Dr Katie Vinen gave an overview of Supportive Care within South London sharing the achievements and the challenges. Slides can be viewed here

Challenges:

Culture – lots of the team do not believe in it as a viable treatment option – getting 'buy In'

Standardisation – Consistent pathways and definition of supportive care

Data – No national data set agreed or reported on. Possibly to include symptom burden, frailty and outcome measures

Discussion points

Supportive care can't be done in isolation – it needs to be a unit approach

Doing an ACP is time consuming and requires skills – convening a meeting for family is also time consuming

Needs a workforce that is skilled and competent

Need a consistent definition of supportive care that can be used

A whole system change is required to embed – create with commissioners

By identifying and working with patients early enough in AKCC and nephrology can impact the dialysis take on rate but needs to be addressed in conversation at start

Agreed targets

Now

1. 50% of patients on RRT identified by SQ to be offered an ACP and conversation started/declined with those who require it
2. All four trusts to commit to data-set decided by SC group for 2020 (final details in work up) – e.g:

- No. patients on ACP
- Patient dying on treatment /place of choice
- Days in hospital on last day of life

3. Report quarterly data on: How many patients in AKCC are labelled as having chosen supportive care - of these how many have GFR < 0r = to 15 but > 10 , how many have GFR < or = 10

To explore for later

4. Develop an implementation plan to collect symptom scores/burden and test it on a small cohort of patients
5. National consultation - How would this work be commissioned? Potential for regional background work on this
6. CQUIN – how could a collective pot be used to further this work? To take up at CD level across four units

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Improving Access to Transplant Project

Work-stream attenders:

Professor Nizam Mamode (co-chair, GSST) Debu Banerjee (StG) Maria Fernandez (StG)

Lisa Silas (GSST) Chris Clarke (KCH) Ray Trevitt (StH)

Professor Nizam Mimode presented the regional transplant slides showing achievements and challenges which can be accessed here

Challenges:

On average it is taking over 30 weeks from referral to activation

Start/stop clock isn't clear regarding complex/low risk and DNA's

Inconsistent referral process to start pathway resulting in delays

Cardiac testing – access to

Discussion points

Anaesthetists– issues around availability and transplant expertise

E-referral would enable referral more quickly but also allow tests to be ordered at same time and pro-actively. Kings have access to e-referral and a bundle enable simultaneous request for tests

Cardiac testing – are there too many?

Do complex patients require all the investigations that are currently suggested?

DNA rates for tests and OPD prolong pathway

MDT can slow up process – needs more careful management and accountability

Agreed targets in next 3 months

Develop an e-referral within each trust which will be the clock START

Agree and standardise a cardiac work-up with PLC – **share Plymouth agreed work-up**

All patients to commence 18 week pathway and be monitored through data collection

Develop clear START/STOPS within pathway

Aim for 50% of patients to reach 18 week pathway within 12 months – December 2020

Vascular Access Project

Work-stream attenders:

Mr Francis Calder (Co-chair GSST) Sophie Goddard (GSST) Dr Richard Hull (Co-chair, StG)

Annabelle Magdael (StG) Anna Plesniak (StG) Dr Alex Rankin (KCH) Fatima Figueiredo (KCH)

Dr Subash Somalanka (StH) Andrea Whitmore (StH) Rob Gray (KCH) Jay Runham (KCH)

Mr Francis Calder and Dr Richard Hull presented an overview of the vascular access project which can be viewed here

Challenges

Definitive access rates are overall not very good for a variety of reasons

Data collection along the pathway

Accessing the pathway – e-GFR referral inconsistent with subsequent access to access clinic taking too long

Accessing day case surgery as a first option

DNA rates to clinic can lead to line insertion as can late presenters

Discussion points

Day case surgery needs MDT approach to include anaesthetists, surgeons and IR involved as well as theatres

Develop a definition of daycase – 'zero length of stay' or '23 hours' – challenges regarding coding and capturing them all which impacts overall rates

KCH and GSST are looking at RCA of patients presenting with lines for HD to gain an understanding of the problem

KCH surveying patients of reasons for DNA – will report back

Involve waiting list managers regarding DNA rates/access to clinics

A second procedure currently stands at 59%

eGFR referral@<15 – this is a blunt tool and potentially needs an additional marker such as the kidney failure risk equation or KDOQI calculator

The potential of flooding people into system by referring @eGFR 15 and expecting them to be seen by

Targets

1. Confirm current day case surgery rate with an aim to increase overall rate to 50% by December 2020
2. Define day case surgery for coding purposes
3. 2 week referral – collect data for each patient entering pathway and monitor for compliance
4. Report monthly on agreed measures which should be owned locally as well as regionally
5. RCA of each patient who presents with a line – 3 monthly report

Additional attenders

Dr Clara Day – NHSE

Dr Graham Lipkin – GIRFT/RA president

Stephen Cass – SLRCA Director

Ron Cullen – RA CEO

Paul Cockwell - Co-chair KQuIP

Julie Slevin – KQuIP

Catherine Stannard – KQuIP

Rachel Gair – KQuIP

Carrie Gardner, Service Specialist, Internal Medicine - NHSE

Kathy Brennan, Senior Clinical Network Manager - NHSE