KQuIP progress report – March 2020

NHS England

Workstream	Vascular Access
Workstream co-chairs	Mr Francis Calder/Dr Richard Hull

Where are we

- The work stream has a number of key performance targets:
  - 80% of prevalent HD patients to have a functioning AVG/AFG (52%)
  - 65% of incident HD patients to have a functioning AVG/AFG (40%)
  - 100% patients within pathway time frame – 'assessment to surgery'
  - Day case surgery rates of > 70% (30-35%)
  - Improve urgent intervention for dysfunctional access
  - Target referral eGFR <15 (range 6-12mls)
  - Target wait for VA clinic <14 days (average 37 days)
- By December 2020, each unit will have increased its overall prevalent fistula rate by a minimum of 5% from Dec 2019 or to above 65%
- To increase the overall day case fistula formation rate to a minimum 50% in all units by December 2020

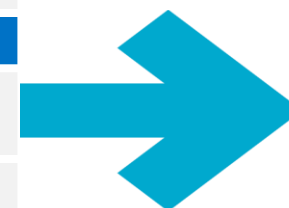
Progress made so far

- Baseline data collected defining prevalent fistula rates
- Raised awareness of GIRFT sourced day case surgery rates
- VA QI leads in each Trust (30-60-90 day plans and local working groups in place)
- First two pathways implemented with regional prospective data collection tool adopted November 2019 against pathway lines

Focus over the next 3 months

- Report monthly on agreed measures which should be owned locally as well as regionally
- RCA of each patient who starts haemodialysis with a line (temporary or tunnelled) – 3 monthly report
- 2 week referral to clinic – prospective data collection for each patient entering pathway and monitor for compliance and trigger QI loops
- Develop a standard definition for day case surgery for coding purposes
- Confirm current day case surgery rate in each unit with an aim to increase overall rate to 50% in all units by December 2020
- Assessment of DNA rate for clinic and procedures
- Confirmation of 'e-GFR trigger' for referral for vascular access assessment / formation

Risks/Issues	Status	Action/Mitigation	Responsible
Data collection	Open	QI monthly meeting/BI role/CSM involved	RG/ co-chairs
Engagement of QI leads – consistent approach	Open	Monthly visits/ quarterly regional meeting	RG/co-chairs



KQuIP progress report – March 2020

Workstream	Access to Transplantation
Workstream co-chairs	Dr Phanish Mysore/Prof Nizam Mamode

Where are we

- **The work stream has a number of key performance targets:**
- Increased % of pre-emptive listing (35%/44% - aiming for 50%)
- Increased % of transplants from living donors
- Increased no. of pre-emptive transplants
- Increased no. of patients entering transplant list
- Improve equity of access – non transplanting centres

Progress made so far

- **Baseline data collected defining time from referral to activation/surgery date Mean 30/32 weeks)**
- **18 week pathway established across region and data collection commenced against it**
- **Bottlenecks identified – referral by letter/ accessing cardiology tests as a 1 stop clinic. Insufficient capacity**
- **Developing e-referral**
- **Joint meeting St Helier/St Georges – surgeons/nephrologist/MDT**

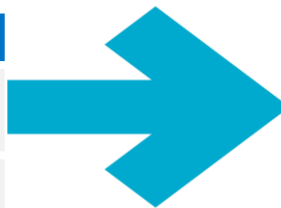
Aim for 50% of patients to reach 18 week pathway within 12 months – December 2020

Patient and donor related outcome measures- 6 months

Focus over the next 3 months

- Data collection against pathway identifying hold ups
- Develop e-referral at St Helier and introduce across region
- Look at high risk patients – majority
- Aim for all low risk patients to hit 18 week pathway
- Process mapping of pathway – St Helier/St Georges
- RCA of those not listed pre-emptively

Risks/Issues	Status	Action/Mitigation	Responsible
Data collection	Open	QI monthly meeting/BI role/CSM involved	RG/ co-chairs
Engagement of QI leads – consistent approach	Open	Monthly visits/ quarterly regional meeting	RG/co-chairs



KQuIP progress report – March 2020

Workstream	Supportive Care
Workstream co-chairs	Dr Katie Vinen/Dr Seema Shrivastava

Where are we

AIM: Facilitate appropriate patients in low clearance and on RRT to commence a supportive care pathway as a realistic treatment option. To support timely commencement of this with follow up by skilled and competent workforce.

Key performance indicators:

% of patients requiring an ACP in HD population using SQ

unit	Total HD	SQ suggests ACP	ACP offered/ started
STH	883	478 (54%)	79 (16.5%)
GST	643	196 (30.5%)	45 (23%)
KCH	593	110 (19%)	29 (26.4%)
STG	320	91(28.4%	4 (4.4%)

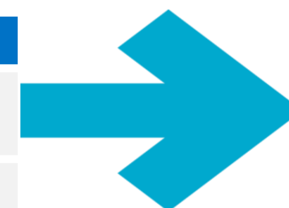
Progress made so far

- **Baseline data collected defining debt in HD population**
- **Staff survey to understand knowledge & skills pertaining to SC**
- **Agree target of 50% of above to be offered/conversation started of an ACP**
- **Draft patient information – needs infographics**

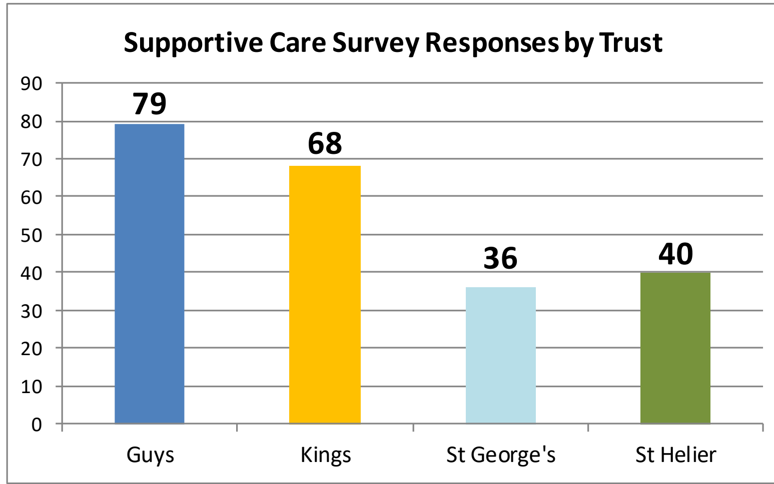
Focus over the next 3 months

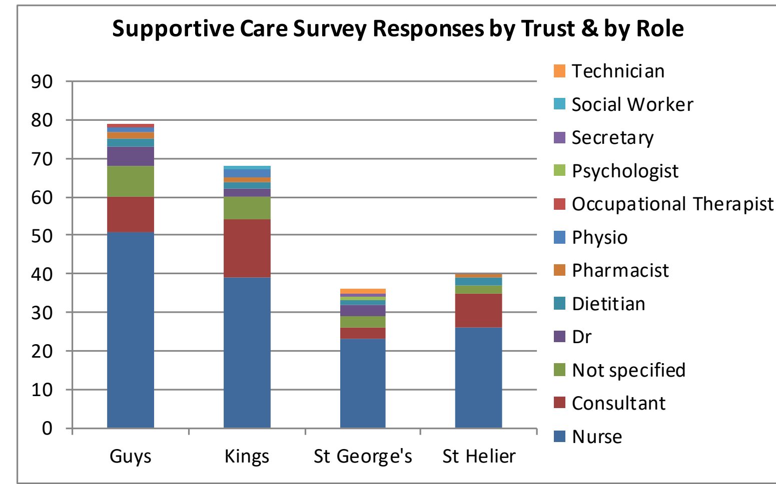
- **Report on agreed measures which should be owned locally as well as regionally**
- **Increase by 3 ACP's per week**
- **Analyse staff survey and develop a communication/education programme that is robust**
- **Agree outcome measures – preferred place of death**
- **Collect ongoing ACP data in AKCC/PD/Tx cohort**
- **Each unit to develop an implementation plan on how this may be addressed**

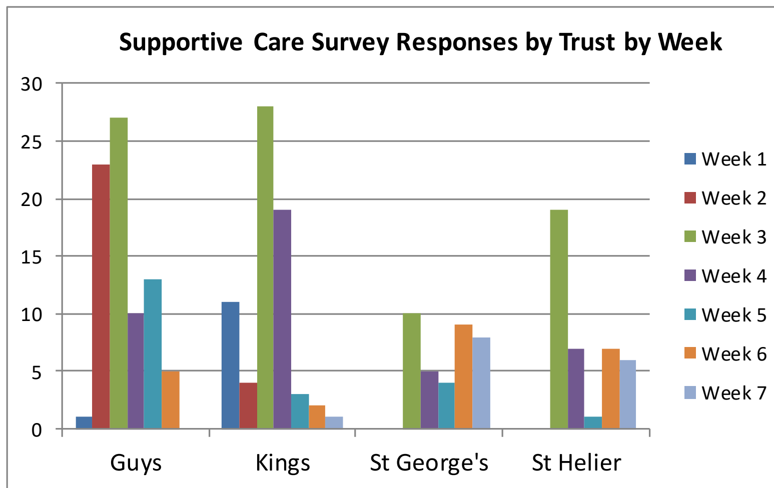
Risks/Issues	Status	Action/Mitigation	Responsible
Data collection	Open	QI monthly meeting/BI role/CSM involved	RG/ co-chairs
Resource - WTE	Open		RG/co-chairs

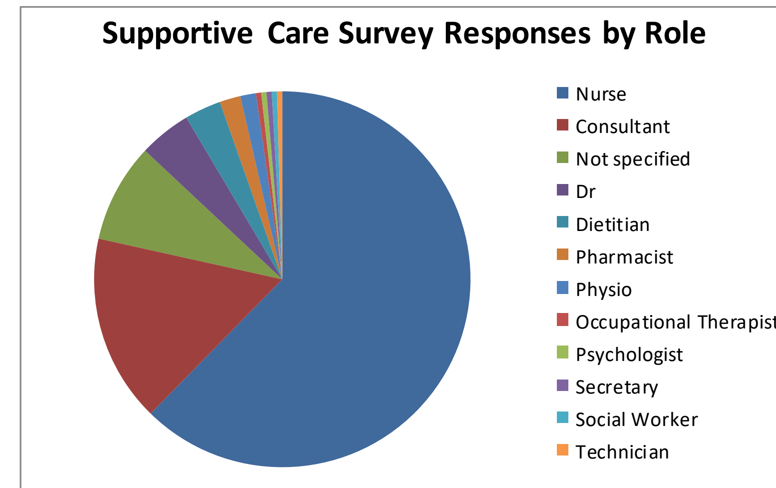


Supportive Care Staff Survey Responses







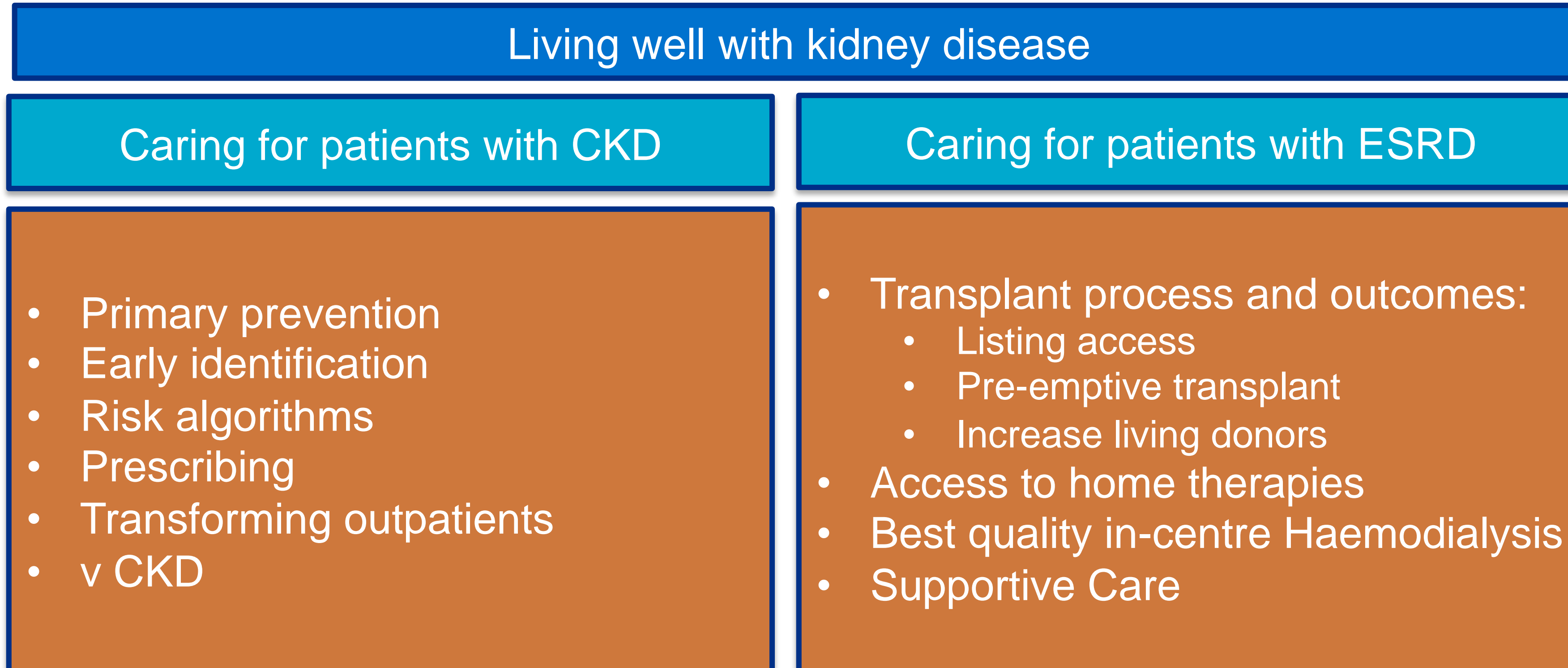


South London Renal Clinical Alliance

NHS

Approach for 2020/21

Target outcomes: Transforming kidney care to make life better for our patients – and become more sustainable



Can we assure patients that we are minimising the risk of their CKD progression?

Can we deliver consistently across South London?

Does every patient with ESRD have proper choice for their care with Shared Decision Making, and are all pathways available?

Are we able to meet expectations?