**How do we increase Living Donor Kidney Transplantation (LDKT)?: Report of a region wide event to identify barriers and solutions.**

The LDKT 2020 strategy aims to increase LDKT rates to 26 per million by 2020. However despite work in this are the rate of LDKT has fallen. Reasons for this are not understood. Some may be positive (e.g. there are fewer patients waiting for transplants and long waiters have in been transplanted), but there is also unexplained variation in LDKT rates in renal and transplant units throughout the UK.

Our region has been supported by our Strategic Clinical Network (SCN) and KQUIP in delivering “Transplant First” a project to increase pre-emptive transplant listing. In April 2018 we again enlisted their support to run a regional event to share process mapping of living donor pathways and discuss barriers to LDKT. We involved the renal MDT, invited (Quality Improvement) QI experts and patients. We identified barriers which are likely to be encountered elsewhere

Funding: Some units were unable to perform tissue typing or virology as their management would not allow it due to lack of funding

Knowledge: Altruistic donors had found GPs unaware how to advise them, low clearance teams were unsure how to advice potential donors

Resources: There was a backlog to psychological assessment of altruistic donors. LDKT co-ordinator time was limited.

Variability: Some units were happy contacting potential donors and other were not. Units performed tissue typing at different stages in the pathway. Some units “batched” donors for a recipient, while others didn’t.

Uncertainty: People were not clear on the “ideal” length of donor pathway, while acknowledging most were too long and can be shortened it was also felt that the pathway could be too short.

The variety of pathways within the region was discussed. Not all variability was justified and units were inspired to adopt each other’s practise where they could see benefit. There was tension between centralising workups and delivering more locally, particularly for smaller units. It was inspiring to see units working together in a much more constructive way since the Transplant First project began.

Some units discussed the results of internal audits. These showed that donors did not seem to drop out due to pathway length. In another LDKT was discussed with all recipients at initial assessment but repeat discussions in low clearance clinics in particular fell off to 50%.

In addition to each unit making changes as a result of the event it was agreed to survey donors on what they preferred, and to work to define 18 week pathway rules for regional implementation.

The group felt that there were many pathway changes that could be made to get an earlier LDKT, which is beneficial. However to increase the overall numbers of LDKT it was felt that much more work was needed “upstream” of the LD transplant coordinator with involvement of low clearance teams and the wider community. Finally the value of the event in terms of allowing teams to come together and think was enormous. The wider renal and NHS community needs to ensure regional collaborative working and QI are embedded and funded in our day-to-day work.