Canterbury Process Mapping
KQuIP South East Region
Monday 2nd March 2020

KQuIP is supporting renal units in the South East to improve the quality of care people with renal disease. We aim to:

- Build leadership and QI capability for the future
- Build effective teams
- Work collaboratively, sharing and learning from each other's experiences
- Establish patient/family co-partnerships to work alongside health professionals
- Develop learning communities, growing from the collective successes and failures
- Adopt Quality Improvement methodology to deliver our desired outcomes

Kent and Canterbury Hospital renal unit hosted a process mapping session, attended by 21 people—patients, carers and staff.
The aim was to find out what causes delays in the system and to think about improvements to be made.

Introductions and agenda

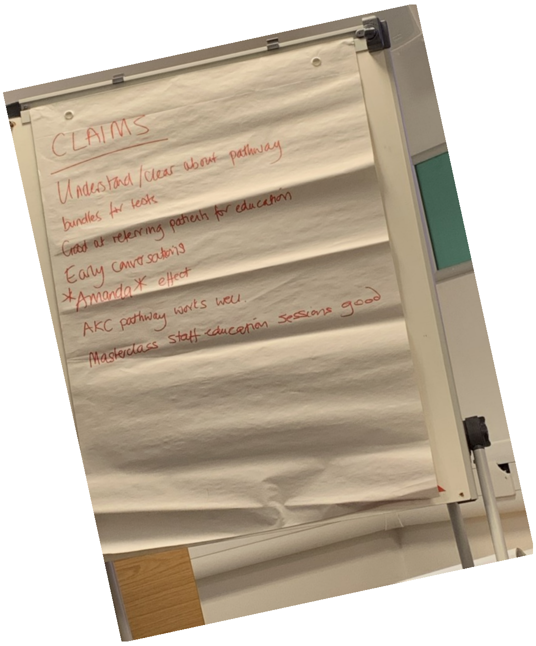
Dr Hannah Kilbride welcomed the group and described the planned outcomes of the session.
The aim of the project in the South East is:

In three years, 95% of all patients starting dialysis, who have been known to us for three months, are actively listed, referred to the transplant team or documented as unsuitable, and this is communicated to patients in a way that is

Claims and Concerns

Dr Michelle Webb invited delegates to think about what is done well in Canterbury:

- We understand and are clear about the pathway
- Bundles for tests
- Early conversations
- The "Amanda" effect
- AKC Pathway works well
- Masterclass staff education sessions are good



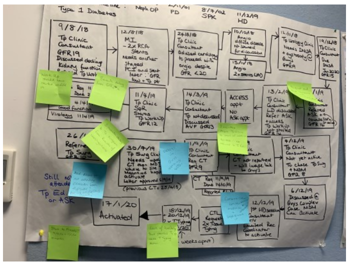
CLAIMS
Understand / clear about pathway
bundles for tests
Good at referring patients for education
Early conversations
Amanda effect
AKC pathway works well.
Masterclass staff education sessions good

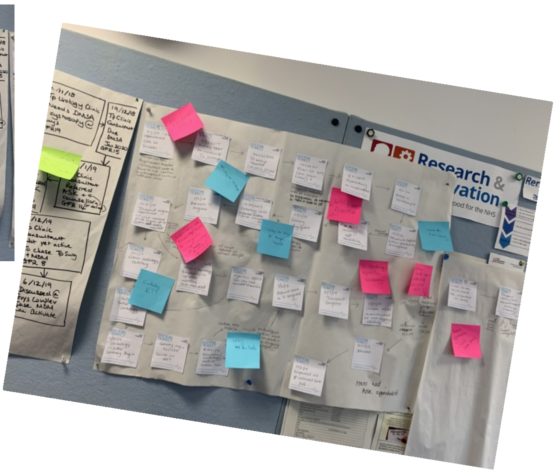
Areas for concern:
Ability for patients to by-pass education events
Communication—joined up between subspecialisms
Transfer between services not as smooth as it could be
Interspeciality referrals
Pick up of results and communication to patient
Renal plus not filled in
Visibility of pathway—staff and patient
Patient View—do patients know about it?
Time to think and lack of privacy HD rounds
HD patients not knowing when the doctor is coming back
Transplant surgical review wait and time for correspondence to come back
Transplant surgeons don't request tests
Crash landers—decisions not made before starting dialysis and information getting lost between units
Loss of information with transplant
Transplant database not used
Transplant centre transplant MDMs—delays in decision making—extra tests and more goalposts
Clarity re risks and benefits of transplanting early
Decision when to transplant
Inconsistencies of approach—surgeons and nephrologists
Over investigation
Post transplant—knowing more information re difficulties likely to have with some patients—eg reading/writing/language
Too many cooks
Historically dialysis first
Clarity about who is eligible—flood gates opened.
Variation in structured approach to dealing with all problems in clinic and ensuring nothing missed.

Process Mapping

Process mapping is a way of creating a visual picture of how the pathway currently works, capturing the reality of the process, exposing areas of duplication, waste, unhelpful variation and unnecessary steps.

Ten transplant recipient pathways had been mapped, and delegates were invited to add comments, spot waste and make suggestions for improvements.





Issues identified:

The group were invited to share any current issues:

Really clear guidance is needed for when it is OK to transplant

Urea levels

Clarity around age limits and BMI

Consistency on investigations required

Number of times in matching run

Patient perspective

- **Knowing what tests are needed and the results**
- **Clear expectations around timeframes**

Continuity—too many different consultants

How do we decide who comes to transplant education?

Should we have a single process for referral to transplant education?

Change ideas:

The following suggestions were made:

Patients to be given a “passport to transplantation” to include details of who to contact

Patients to be empowered to contact us to let us know that tests have been done

- **Generic? (admin)** ↓
- **Pull up result** ↓
- **Email consultant**

Patients given a link nurse contact

Survey patients—would they like workup

- **On HD unit**
- **Attend a clinic appointment**

Nobody starts dialysis without a transplant status recorded

Half page formal referral for ASK (proforma)
- decide where to go.

Named consultant and contact details

Canterbury AKC patients point of contact, who is responsible?

Move to AKC

Next Steps:
The next KQuIP education meeting is on 30th March at Guys hospital. Change ideas will be developed and plans to test them out.
If you would like to register to attend the event, please use the following link:
https://www.thinkkidneys.nhs.uk/event/kquip-south-east-launch-event/

Contact Julie at KQuIP for more information:
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