National Kidney Patient Survey

Improving patient experience · Case study

Improving transport for dialysis patients

King's College Hospital

Acting on the Kidney PREM results

UKKA UK Kidney Association

Kidney Care UK

Patient transport and the changes made

Shared by Helen Cronin, Matron for satellite services

1) What aspect of patient experience did you want to improve and why?

I meet with patients regularly on the satellite units and keep them updated with transport - it is the main issue of concern for most patients and is on the agenda at our ongoing satellite patient forum meetings.

When the Kidney PREM results came out last year, we shared the results locally at these patient meetings. We also discussed it at our dialysis Haemodialysis Quality Improvement (HDQI), Care Group and performance meetings where transport is always an agenda item. With the support of my Renal consultant lead who is the corporate Medical Director, Quality Governance and Risk, we presented updates at the Trust patient experience committee. The consultant lead and I continue to work very closely at addressing transport provision and he has played a huge part in the success of this project.

2) What changes did you make?

Firstly, we set up monthly meetings with the transport providers, made sure that patient experience and performance data was discussed at each meeting and created an ongoing action tracker to capture activity and progress.

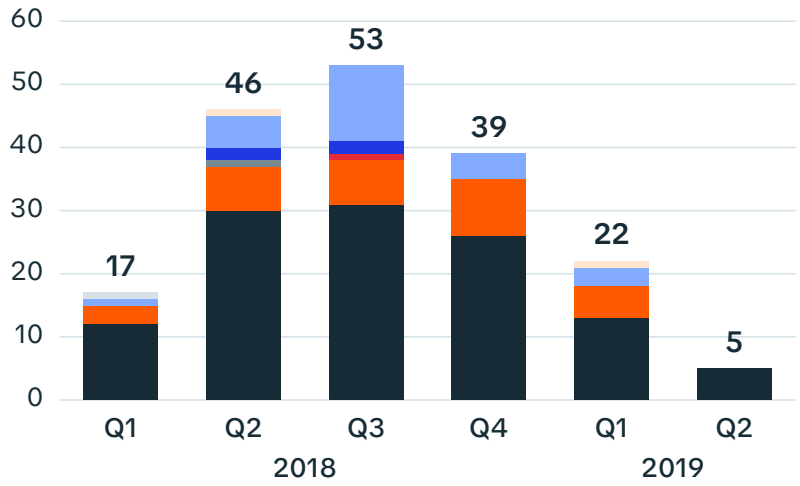
We then rolled out clear escalation policies for each transport company and ensured that both transport providers met with relevant patient groups on a rolling basis to hear feedback and discuss plans for quality improvement.

We joined the South London Renal Operational Delivery Network for transport, which allowed us to swap up to five patients with Guy's and St Thomas's - this was significant and improved patient journeys bringing them closer to home.

Finally, we worked together to review and revise transport contracts with one of the providers to ensure tighter control of key performance indicators.

3) What was the outcome?

Incidents by quarter



Incidents by type

Incident type	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Patient taken to wrong destination	0	1	0	0	1	0
Patient not taken to final destination	1	0	0	0	0	0
Other transport problems	1	5	12	4	3	0
No transport available	0	2	2	0	0	0
Incorrect/inadequate secure fittings	0	1	0	0	0	0
Inappropriate use of transport	0	0	1	0	0	0
Failure to collect patient	3	7	7	9	5	0
Delay in collecting patient	12	30	31	26	13	5

All of the above is ongoing but we have managed to reduce Abort Incidences (AIs) related to transport significantly as shown in the table above, and we work much closer with the transport providers. We have reached a point where we can review patient journeys and work at improving those that are problematic. We keep a tighter rein on aborts, but overall, we have improved the transport situation considerably from where it was when we first set out on the journey in 2018.

This was a real team effort and is something we feel very proud of.