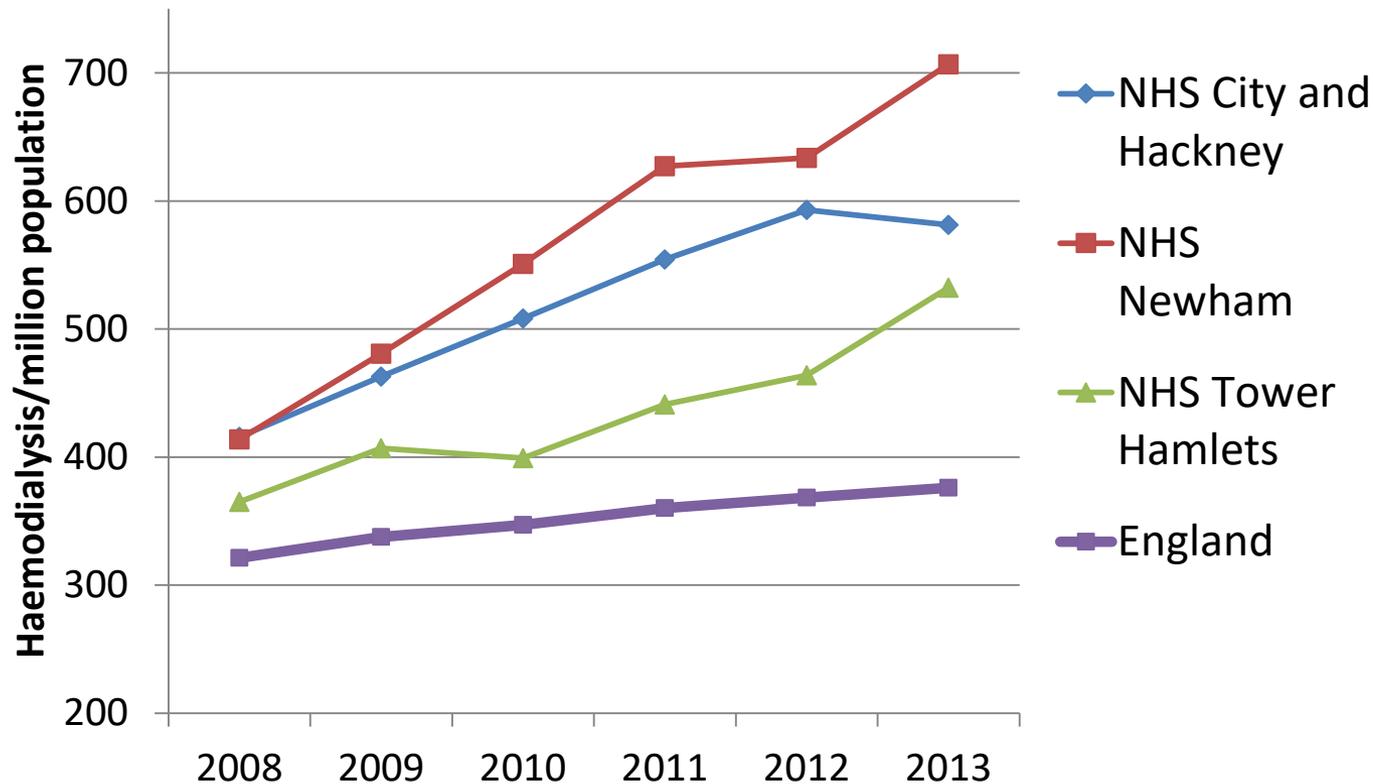# A Different Perspective

Dr Saurabh Chaudhri

Consultant Nephrologist & Acute Physician

Whipps Cross Hospital

Barts Health NHS Trust

What is the Problem?

Fast rising ESRD rates in East London – ever more people needing dialysis
Haemodialysis rates per million population, 3 East London Boroughs

Data from the UK Renal Registry 2015

Ambition…

- Reduce incident ESRD growth by 2020

- Stabilise prevalent ESRD cohort in East London

- Single pathway from primary to secondary care

- Reduce unnecessary referrals and increase discharges from secondary care

- Increase skills in CKD management within primary care

- Improve care & experience for patients in East London with CKD

What are we doing about this?

- A single integrated system of kidney care in East London

- An example of IT-driven integrated care that reduces cost in primary & secondary care

- Every patient with CKD identified and reviewed – *'Right care at the right time in the right place'*

What are we doing about this?

1. **Community CKD eClinic**
Community-based Nephrologist doing e-clinic in EMIS Web
Referrals ALL electronic (through e-referral)- unless urgent
All reviews and opinions recorded in EMIS Web
Locally relevant guidelines.

> E-referrals and local guidelines

2. **Practitioner and Patient education**
Practice based education for clinicians
Patient one-on-one and group education

> Community based education

3. **Community CKD overview**
CKD Prevalence searches to find un-coded patients
CCG/Practice dashboards with KPIs
'Trigger tools' to alert GPs to patients with a falling eGFR

> Find and code cases

> Practice safety alerts

Community CKD e-Clinic

Who to refer to the community renal clinic?
   everyone previously referred to outpatients.

How to refer to the community renal clinic?
   Write your question in the patient record.
   Ask for patient consent to view the record
   Use the e-referral service

When will my patient be "seen"?

   Next week – responsive to demand

Outcomes

- **<u>THERE ARE ONLY 3 POSSIBLE OUTCOMES</u>**

1. Discharge to GP with Advice
2. D/C TO SOS –Review virtually after a period of time on a future vCKD list
3. Face to face hospital appointment

After every e-clinic appointment a notification email will be sent to the practice nhs.net email advising to view the shared record.

Early Wins for the service

Waiting times for consultant advice slashed!

- In the six-week pilot period 19/35 practices referred into the community e-clinic.

- Over 70% of referrals are managed without the need for patients to attend a hospital appointment.

- During 2015 the average wait for a renal clinic appointment was **_64 days_**. Using the e-clinic the average time to get nephrology advice is **_5 days._**

GPs say…
A model for future care happening right now in Tower Hamlets!

Consultants say…
We can provide comprehensive management advice whilst avoiding unnecessary duplication of tests.

"in some ways it puts more pressure on me…. and certainly additional tasks with the monthly case reviews."

Fund GPs for shifting work out of hospital

We have referred 9 patients overall since it began. 6 during routine care and a further 3 people identified using the renal trigger tool.

Community review means more referrals to nephrology

"Biggest problem is that I haven't used the service enough to remember how to refer - so I struggle to remember how."

Make it *SERIOUSLY* easy to use

"The note regarding response time is misleading. Although response time is quick compared with outpatient letters it can take up to 2 weeks to receive a reply."

The 'new normal' is established very quickly

Measure of value of service

- FA & FUP seen (both activity and cost) p.a. from 2011 onwards (i.e. trajectory of growth)
- New starters to dialysis from 2011 onwards
- % CKD coded per practice
- Practice-based use of e-advice & guidance

General Nephrology FAs vs vCKD 2016 CCG A
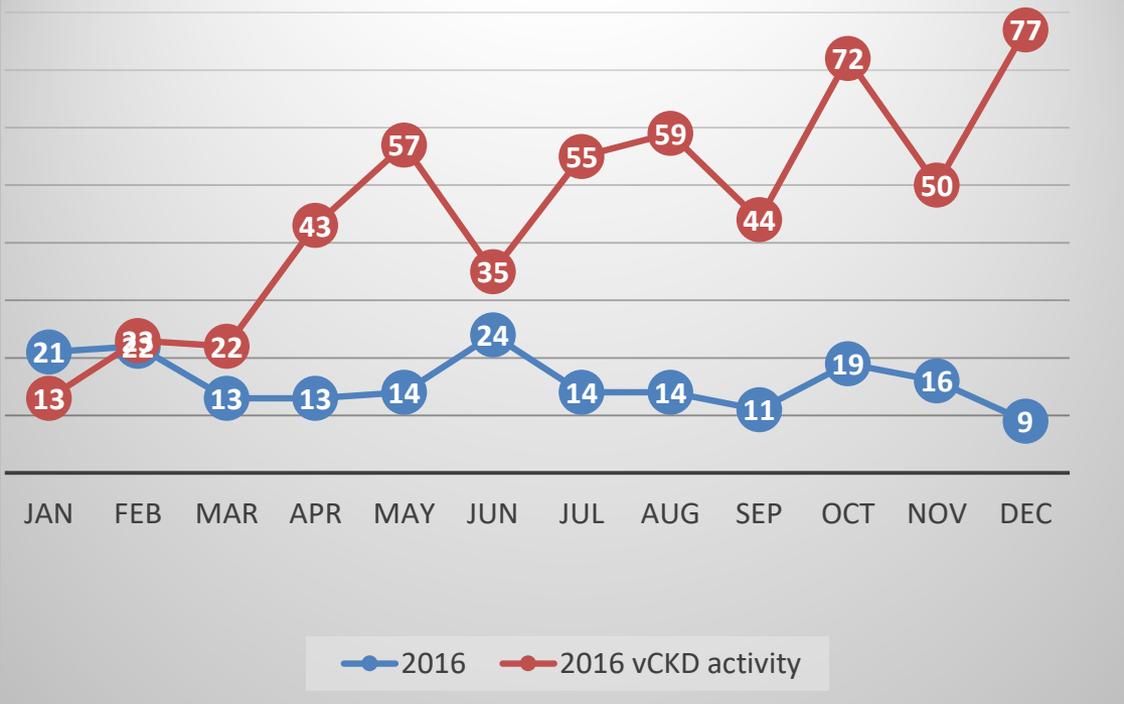
	Bur A		Bur B	
	15-16	**16-17**	**15-16**	**16-17**
FA	276	⬇ 190	**356**	⬇ **273**
% diff		⬇ **-31%**		⬇ -23%
no. diff		⬇ 86		⬇ 83
total savings in year		⬆ £28,036		⬆ £25,784

Patient Education: 1-1 and group education

Innovative materials developed with patients including the 'conversation map'

"Diabetes Conversation Maps™ are effective for diabetes self-management education and facilitate behaviour change in people with type 2 diabetes." (Ghafoor 2015)
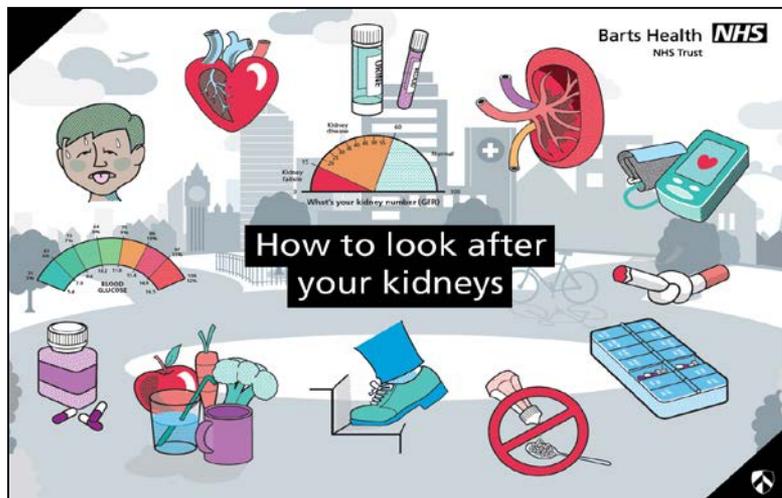
Evaluation: the first year of patient education

147 seen in 1 to 1 clinic – 77% attendance
46 came to 12 group sessions – 41 % attendance

We surveyed patients after the first six months of the service

HAVE YOU CHANGED ANYTHING?
"I try to eat less salt, exercise more and am trying to give up smoking"
1 to 1

HAVE YOU CHANGED ANYTHING?
"Yes, I eliminated the foods high in salt. I stopped taking NSAID"
Group

Primary Care Staff education

## Supporting Continuing Professional Development

1. Presence at locality education meetings which include GPs, Nurses, HCAs and Managers

2. Community staff training– including diabetes teams and Health Trainers

3. Practice nurse group education:

Including

> Setting the scene of CKD in East London
> How to explain CKD to people
> Involving patients in self-management
> Identifying progressive disease and referral

Providing resources developed with patients

– booklets and films to self-manage kidney disease

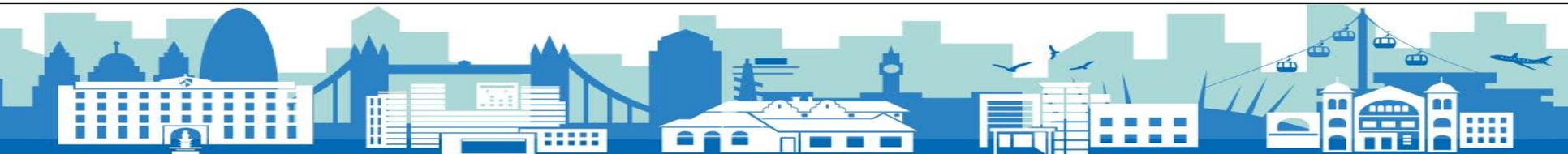https://bartshealth.nhs.uk/renal
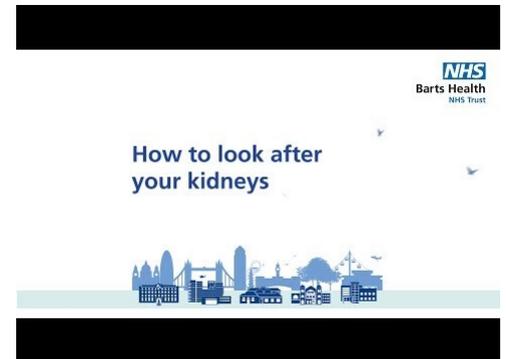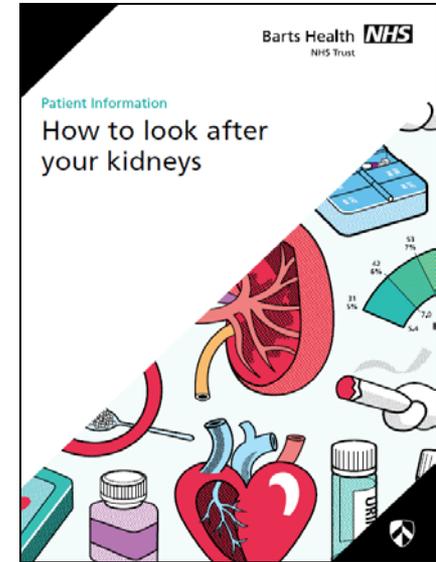
The patient at the centre

- Reduced travel/ cost for patient
- Only needs to come to hospital once confirmed necessary, work up in community
- Productivity in general ~ pt time off work
- Effect on carbon footprint of the NHS
- Reduced exposure to pollution and infection risks

Teams perspective

- Reduced transport requirements
- Reduced overheads: clinic room, lighting, staffing for clinics, management around clinic spaces
- Right care at right time at right place
- Integration of care in community

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Thank you