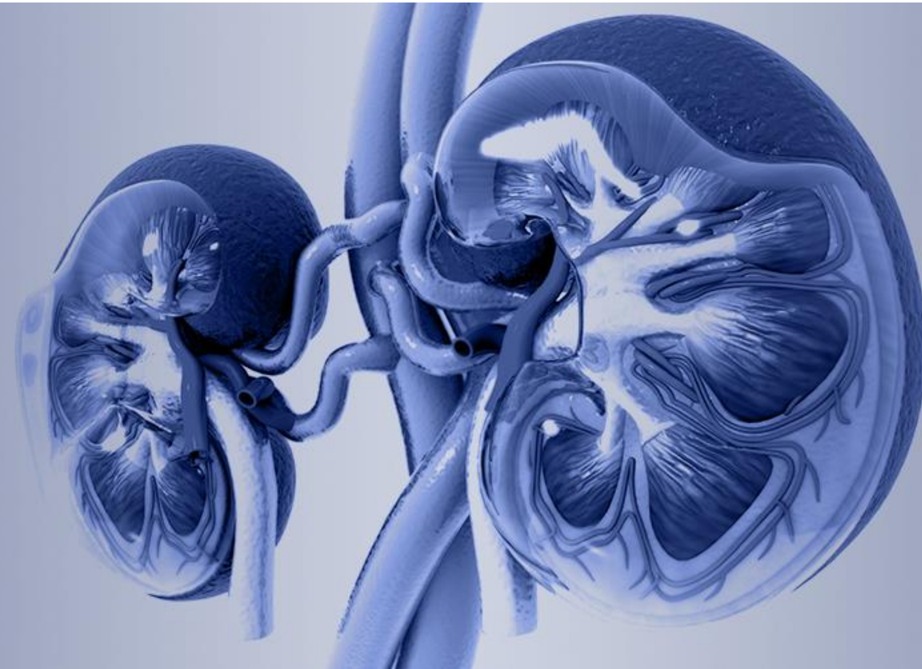
London Kidney Network- PD scoping
May 2021



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Scoping exercise -

- Met with PD and HHD teams and in some cases the AKCC teams
- A mix of medical and nursing leads
- These are the initial draft findings for PD presented as following themes:

➢ Workforce

➢ PD culture

➢ Medical insertions

➢ Policy/protocols

➢ SDM

➢ Education/Training

Workforce

- **4/7** units have **separate** PD and HHD teams.
- Remaining **3/7** units have varying degrees of integration;
- **7/7** have one lead nurse for PD and one for HHD
- **1/7** has a home therapies team incorporating PD/HHD with a shared consultant lead
- **7/7** units offer community visits to support patients when they first start PD.
- **2/7** units provide nurse visits to frail patients at home offering support for remote consultation reducing the need to attend clinic
- **1/7** units has a PD / AKCC nurse (funded by AKCC) this helps to promote PD in LCC

Workforce - WTE

- Ratio of WTE: 100 PD patients ranged from 4.46 – 5.52 WTE (registered/unregistered) – this ratio included 2 admin staff in **2/7** units
- Ratio of registered to unregistered staff varied from 7:5 to 8:1 across Trusts
- All units reported unfilled nursing posts due to vacancies / maternity leave / sickness, this varied from 11-30% of total PD nursing workforce –
- **5/7** units had their PD teams depleted by redeployment during COVID

Leadership – PD culture

- **2/7** units had a PD first or home therapies first approach
- **2/7** units had a patient choice approach
- **3/7** units did not have an explicit approach but there was a desire to support people to start PD,
- **1/7** units had a target number for PD
- **4/5** units had a combination of consultant led and nurse led clinics.
- **1/7** unit had consultant led clinics only and were looking to develop nurse led clinics which would require nurse prescriber training

Medical insertions

- 5 /7 (at least) units carried out medical IOT – +ve impact on PD numbers
- 1/7 unit felt that they can even run a weekend service for acute/unplanned starters as a result of nurse and medical consultant IOT, although recently they haven't had many referrals for this weekend service.

Policy

- 1 unit had a traffic light system to highlight risk requiring increased support
- 1 unit commented that providing PD bags with antibiotics in the bags was helpful for patients
- Defined training pathways – AAPD/APD/CAPD
- Defined peritonitis/exit site protocols
- Acute PD offered in some units

SDM - PD

- All units provide education sessions in AKCC – latterly remotely
- One unit has a joint PD / AKCC nursing post
- **5/7** units refer to the PD nurses for a more detailed education session, the nurses feels that this helps to manage expectations and perhaps prevent 'drop out' rate if this is done early before the catheter is inserted
- A patient peer support service available to help with SDM but not across all units
- Translators/family involvement to help with SDM
- Disability/age/weight/housing (unless homeless) doesn't preclude PD

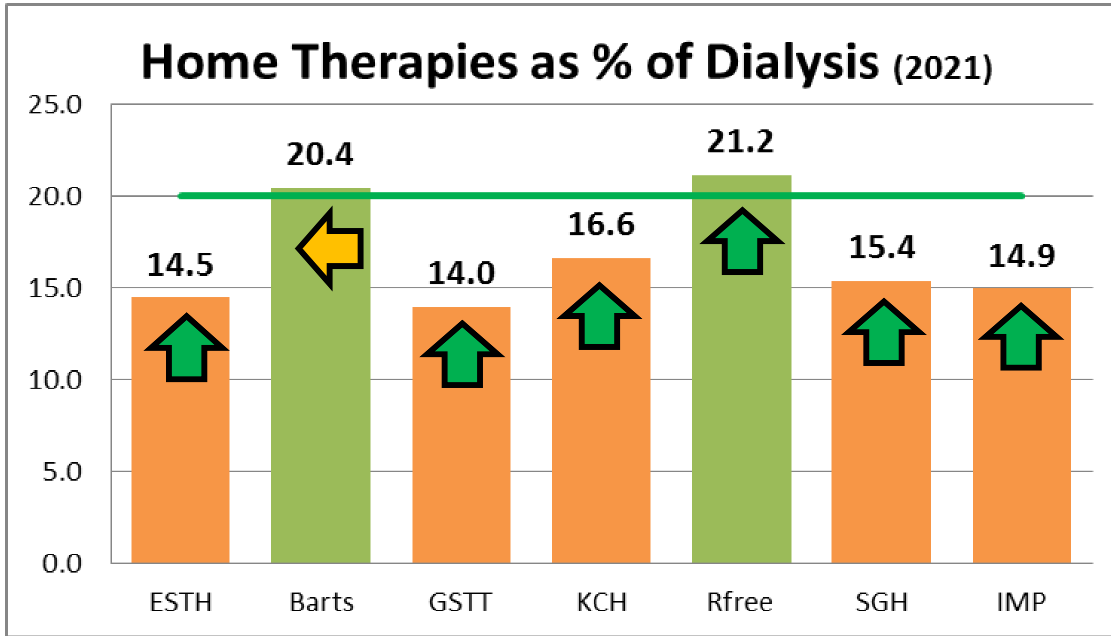
Training

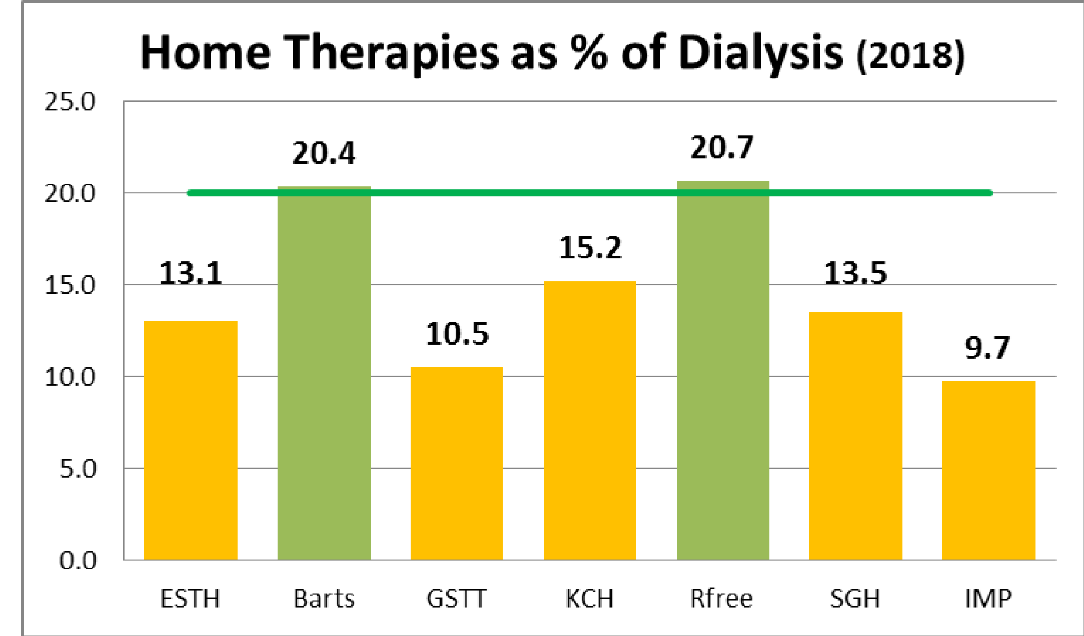
A variety of different models using Baxter & Fresenius:

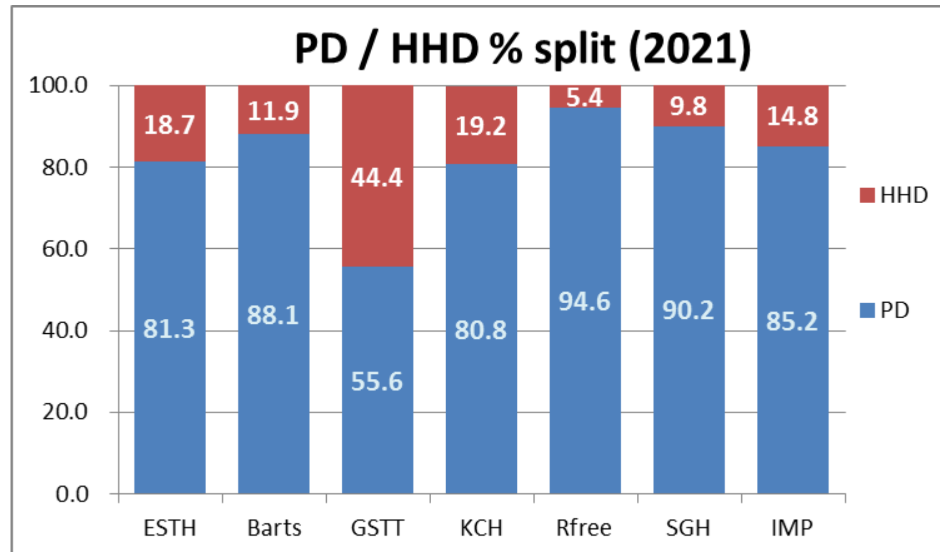
- Baxter site for training all patients
- In house training using Baxter site intermittently – felt this provided a quality service & good patient engagement/technique
- Baxter site but provide training for acute starters
- In – house refresher course in some units – Baxter doesn’t provide this – a challenge to meet need with current workforce

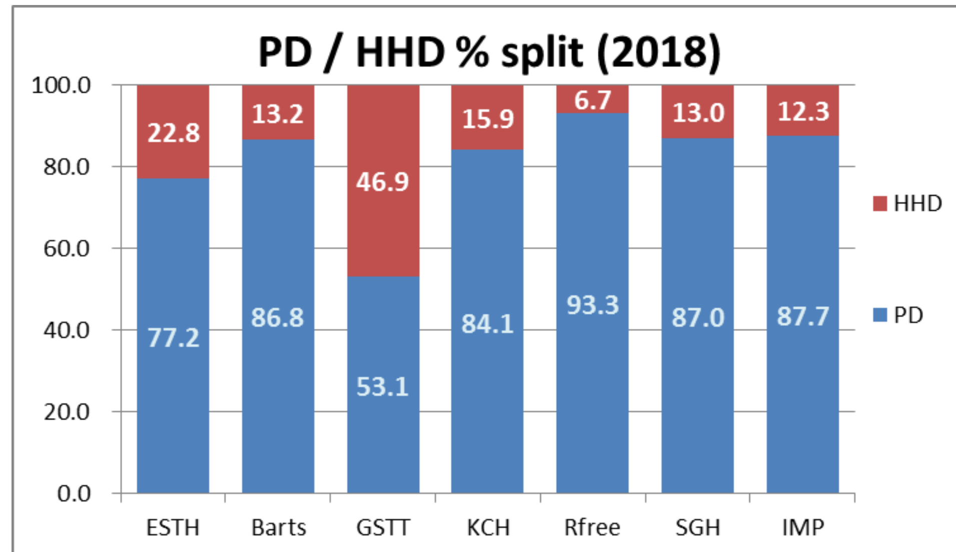
Data / Measurement

NHS London Kidney Network









6. Ensure home therapy is promoted and offered for all suitable dialysis patients and that a minimum prevalent rate of 20% is achieved in every renal centre.
6a. All centres to ensure adequate training facilities and staffing for home HD (HHD) and PD, sufficient to deliver the 20% target. (Centres to consult the staffing models outlined in the British Renal Society (BRS) workforce document.)
6b. The reduced risk of transmissible infection (e.g. COVID-19) for patients on a home therapy compared with in-centre HD (ICHD) to form part of the SDM process with patients.
6c. All centres to ensure they have a timely PD catheter insertion service. (Local resources will determine service design but a percutaneous method of insertion will become standard in most centres.)
6d. All centres to establish a late start PD service.
6e. All centres to ensure collaborative working within renal networks is in place to improve the resilience of services such as assisted automated PD (AAPD) and HHD, particularly for smaller services.
6f. All centres to ensure that shared care HD becomes a feature of all ICHD facilities in the independent sector and the NHS.
6g. Research to be undertaken to develop successful strategies to address inequities of access to home dialysis in deprived and black and minority ethnic (BAME) populations.

Home Therapies

What we aim to achieve

Overall Aim

Minimum prevalent rate of 20% for home therapies within the prevalent dialysis population of each centre Dec 2022

Improve peritonitis rates to above 0.5 episodes per patient year

(agree % and time frame)

Why is this important

- Avoids hospital attendance
- Cost benefit
- Sustainability

How will we do this

- Each centre to have a shared care programme available to all in centre haemodialysis (ICHD)patients
- All centres to have a timely PD catheter insertion service and a late start PD service using a medical insertion model
- Each centre to ensure PD peritonitis is given equal priority to MSSA/MRSA bacteraemia in the haemodialysis population

What will we monitor to ensure this happens

- % of incident and prevalent dialysis patients having a home therapy
- % of ICHD patients that switch to a home therapy and timescales and vice versa
- % of acute start dialysis patients starting on a home therapy
- PD peritonitis rates across centre
- % ICHD patients participating in shared care (broken down by each unit)
- Patient reported outcome measures

How

- Applying QI methodology
- Agree aim/purpose
- Who – small delivery groups
- Incremental build against time frames
- Support through LKN and KQuIP
- What next?