

Chapter 11: Quality Assurance, Improvement and the NSF

This year the national coverage is again increased. With recent developments there is the real prospect of complete national enrolment. The UK Renal Registry is now on a sound financial and organisational footing, and leads nationally in the area of audit and speciality-based data collection. The Registry has started the process of removing anonymity where the data are reliable.

Each Annual Report has shown a different emphasis, while maintaining the core demographic and quality assurance data necessary for planning and comparative audit. The UKRR Reports have been a vehicle for the early publication of several pieces of work, on Renal Manpower, the Renal Review and now the HTA Satellite Dialysis Survey. These are important to prevent misconceptions both at individual units and the Department of Health, and is especially relevant in this first National Service Framework year.

There is evidence about the validity of the Registry data. Comparison with the Renal Review data in the 2000 Report showed the demographic and clinical outcome data from the Registry to be representative of the UK as a whole. Successive Reports show consistent findings in the clinical variable distributions. Further progress at renal unit level has been made in recording patient ethnicity and co-morbidity, as demonstrated in this year's document. A yet greater improvement is required, particularly if reliable comparative mortality data are to be presented in future. The agreement to progressively release the anonymity restrictions at renal unit level should act as a spur in this effort, since under-reporting of co-morbidity will always tend to portray unit outcomes in a worse light than necessary.

Experience from undertaking Registry activities suggests that a more explicit and structured approach to quality assurance and improvement is required, in order to support the development of the Speciality in the light of audit data and the Standards Document. The Registry itself is not mandated or resourced to translate its findings into action at Unit clinical level. This problem is clearly illustrated by the persisting weakness of the data on dialysis dose (URR), because of indeterminate post-dialysis sampling methods. It is not currently the task of any particular renal group to consider Registry findings and then influence the clinical community to improve methodology and outcomes. While it may be more comfortable to leave such a default, given the many day to day pressures with which clinicians grapple, it will be hard to maintain the initial impetus of the Registry, and its support, if the findings are not fully employed to improve and develop management of renal patients. The UK, through the Registry, has a unique potential in Europe to translate this national effort into continuing quality improvement at the level of patient outcomes. Further consideration of the structures of the audit cycle will be required to capitalise on this lead position.

A National Service Framework for renal services is in process of production. This is therefore a very important year for the UK renal community. This report, should contribute significantly to the NSF and the further development of the Speciality. If appropriately resourced, the database should in future be pivotal in the monitoring and development of the NSF.

