UCLPartners

Chronic Kidney Disease clinics at the Royal Free Hospital

Case Study

IT challenges during the implementation of non face-to-face (Nf2f) Chronic Kidney Disease (CKD) clinics – Royal Free Hospital.

Background

Nf2f clinics based at the Royal Free Hospital to cover Camden, Islington & Barnet CKD and Camden community hypertension services.

GPs refer patients via the EMIS web template that provides a referral pathway or criteria for their patients. The consultant nephrologist and one of the lead nurses for CKD and hypertension then triage the patient into one of three outcome pathways:

1. Discharge the patient back to the GP with an individualised care plan that contains management advice. GP is advised to refer back to the service should they wish the patient to be reviewed again if anything changes. The patient does not get a copy of this care plan.
2. Patient referred to the community nurse-led clinic for an intervention, such as improve BP control or fluid management. The patient receives a care plan and the GP gets a copy. Once stable, the patient is discharged to the GP.
3. Patient referred to secondary care diagnostic clinics for further investigation and diagnostics, or to one of the specialist clinics, such as renal genetics or vasculitis.

The key performance indicator (KPI) is that any referral is triaged and the GP receives a care plan within two weeks. We are measured against this KPI and the CCGs receive a regular activity report to demonstrate this.

Sheila Johnston
sheilajohnston@nhs.net
Lead Nurse for Nephrology
Royal Free Hospital

Case Study

Lessons learnt

- Engage early with CCG IT/EMIS and do the search set-up together to avoid variation. Ensure CCG IT agree what data they will collect and how often to meet your report deadlines.
- Visit larger GP practices when you first launch and do list reviews together with GPs. This increased our referral rate and supports the GP in familiarising themselves with the CKD template and pathway.
- Ensure you have adequate admin support – ideally, the individual should be familiar with EMIS and running searches. We found that a great deal of clinician time was spent on troubleshooting IT issues. This was greatly reduced when we recruited an excellent administrator who helped immensely.
- Engage patients and encourage them to join the STP committee – we find their involvement invaluable in co-designing services.

The IT challenge

Before referral to the Nf2f CKD service, GPs must gain consent from patients to share their clinic information with the CKD team. The GP then activates shared records on EMIS so the CKD team can access the relevant clinical information – this enables us to give an opinion and advice. We have access to a patient's problem list, medications and all documentation from other health teams, investigations and GP consultations. The CKD team can then provide the GP with contemporaneous advice and guidance.

Activating shared records is only effective if the GP surgery is using EMIS and not another electronic system. This has been challenging when we receive a referral from a non-EMIS surgery. In these circumstances, our administrator needed to contact the surgery to request that they email the relevant information, which was then scanned on to EMIS. Although this is very time consuming, most GPs across our geography are now using EMIS.

Case Study

In our experience, it's vital for the CKD Nf2f clinic to have an EMIS trained administrator to manage patients, book appointments, arrange transport and interpreters, and take a lead role with data collection to demonstrate our compliance with KPIs. This has been a challenge, as our admin support has not increased in real terms as services have grown. It's extremely important that adequate admin time is built into any contract with CCGs to provide Nf2f clinics.

The key stakeholders to robust IT support have included community IT, CCG, EMIS, clinicians and primary care teams for long-term conditions. It's important to have transparency for the data gathered from EMIS and to identify whose responsibility it is to collect, collate and present it.

Overcoming the IT challenges and delivering patient benefits

We had regular meetings with community IT from the CCG to agree the CKD template and the searches required. Progress was very slow as IT resource was initially funded by the commissioning support unit (CSU). However, the IT resource was reallocated to another project and we struggled to get consistent IT support. After escalating this problem to the STP committee in 2017, we did gain some momentum. The CKD GP template is now agreed and is live across all the CCGs who have commissioned Nf2f CKD services. We've agreed the CKD pathway and it's also live now. This pathway helps to embed a standardised approach for GPs to refer patients to the most appropriate nephrology service.

Some progress has been made in getting accurate data reports from EMIS. This process has been arduous, partly due to the functionality of EMIS, as well as searches being set up slightly differently across each CCG. This situation was caused by a frequent turnover of IT information analysts, each of whom had a marginally different approach. Also, the coding on EMIS differed somewhat across the CCGs, which complicated the searches and made some data reports inaccurate. This has required a lot of clinician time and effort to drive IT problems forward to receive accurate reports that demonstrate compliance with our KPIs. We now have regular activity reports from the CCG IT. However, because we still see occasional errors, our clinicians need to sense check reports to confirm accuracy.

The service collects and presents quarterly data to demonstrate compliance with our KPIs. This includes:

Case Study

Process data collected	Outcome data collected
Number and percentage of referrals to the Nf2f CKD service.	Number of patients on the CKD register.
Number and percentage of patients: • with a plan within two weeks (target >90%). • referred to secondary care (target 33%). • discharged back to the GP with a care plan (target 33%). • referred to the community CKD nurse-led service (target 33%). • re-referred to the Nf2f CKD service within three months. • discharged back to the GP from the nurse-led clinic. • transferred from the nurse-led clinic to secondary care within three months.	Percentage of patients on the CKD register: • for the CCG adult population. • who have had an eGFR and urinary ACR/PCR recorded in the last 12 months (target >80%). • with urinary ACR>30 or PCR > 50 with BP <130/80 mmHg in under 80-year-olds (target >50 %). • Percentage of patients on the CKD register with urinary ACR <30 or PCR < 50 with BP <140/90 mmHg in under 80-year-olds.
Number of new and follow-up patients who attended the nurse-led clinic.	Prevalence gap increase in case attainment per year.
Percentage of patients who: • did not attend (DNA) (target <10%). • respond to friends and family test (FFT). • responded that they're extremely likely or likely to recommend the service in FFT (target >80%).	
Number and percentage of GP practices who received on-site education per year.	
Percentage of patients and GPs who are sent a care plan within two weeks of the nurse-led clinic attendance date.	