Renal GIRFT
Where are we and what’s next?

Renal CD Forum
23rd May 2019

Will McKane

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement
Overview

• Where are we?
• Emerging themes
• Procurement
• What didn’t we measure?
• Peer Assist
• National Report
• GIRFT/UKRR Fellowship
• Next steps
Where are we?

• 49 of 52 visits
  • Paid a price in terms of timeliness of reports
  • Excellent clinical engagement
  • Less consistent senior executive engagement

• First steps towards a National Report
  • Co-badged with RA/BRS/RCP
Emerging themes

• QI processes
• Data
• The “predictable three”
  • Vascular Access
  • Transplantation access
  • Home therapies
• AKI requiring nephrology input
• Infection
• Hospitalisation
• Medicines management
Data – not as good as we aspire to

- UKRR
- Use of correct HRGs in dialysis and transplantation
  - HES and reference costs, MDT tariff
  - Commissioning disincentives
- Dashboard infection metrics
- Good data requires
  - Culture across whole multi-professional team
  - Dedicated data manager
  - Renal EPR that is fit for purpose
  - Pros and Cons of renal EPR that is separate from trust EPR
Adult transplant follow-up activity recorded using LA13A in 52 renal centres 2017-18

11/19 transplant centres in red

2019-20 tariff
Nephrology f/u £124
Transplant f/u £228
Vascular Access

66% nationally
Vascular Access

- Stretched capacity in the NHS in England
  - Theatres/Vascular labs
  - Surgeons
  - Interventional radiology
- Co-localisation
- Time for a radical re-think?
  - Dedicated VA centres covering large urban areas?
  - Independent sector involvement?
- 59% of patients need more than one procedure before starting dialysis
Equity of access to transplantation

The percentage of patients on renal replacement therapy who have a kidney transplant - 2016

*Opportunities are not provided for this indicator as the appropriateness of rates of renal replacement therapy is very much a matter for local interpretation based upon specific population requirements/needs.

In 2016 there were incomplete PRT acceptance rate submissions from Cambridge renal centre. The following CCGs were affected:-
NHS Cambridge & Peterborough
NHS West Norfolk
NHS South Norfolk
NHS West Suffolk

Source: UK Renal Registry of the Renal Association [https://www.renalreg.org/]

GIRFT
GETTING IT RIGHT FIRST TIME
Home therapies

• Varied clinical views
  • HHD v PD
  • What drives HHD?
    • New technologies
    • Shared care HD

• Percutaneous PD catheters now the norm

• Training facilities a limiting factor for HHD
  • The right environment/space
  • The right staff
AKI Requiring a specialist

- Almost all centres report a delay in transfer
- Access to nephrostomy 24/7
- Huge variation in maturity of outreach services
  - Networked acute medicine physicians with renal CCT
  - AKI outreach ANPs
- Data
  - Very few trusts using the AKI-HD HRG
  - Few trusts reporting AKI-HD to UKRR
- Needs strengthened standards
Delayed transfer in AKI

Days to first dialysis in AKI

- Admitted to a trust with a renal unit: 6 days
- Admitted to a trust with no renal unit: 13 days

NHS

GIRFT
GETTING IT RIGHT FIRST TIME
Percentage of renal support days delivered to patients with single organ renal support

Source: CMP 2016-2017

Critical care units with at least 10 eligible admissions
O/E mortality for ARF in SHMI dataset July 2017 - June 18
Infection - peritonitis

Number of PD days at centre (over the period 01/01/2018 to 31/12/2018)
What should we do about the profile of the dashboard data?
Hospitalisation

- Under-utilised as a quality standard
- Poor HES data in a few centres skews the analysis
- Significant variation
  - Prevalent HD
  - Prevalent Transplant
  - LoS AKI
  - LoS transplantation
  - Re-admission after transplantation
Emergency hospitalisation in prevalent HD

Emergency inpatient days per prevalent HD patient
Emergency hospitalisation in prevalent HD

admissions per prevalent HD

mean LoS in emergency admissions
Readmission after transplantation

30 day readmission - Deceased Donor
Medicines Management

• Innovation in pharmacy practice
• Barriers to immunosuppression repatriation and generic switch
  • 10% repatriation/generic switch worth £6.5 million per annum
  • NHSE need to take a national stance to support this
• Primary care spend on CKD-MBD drugs £20 million per annum
Procurement

• Poor quality data in PPIB
• Variable quality in questionnaire returns
  • Lack of specificity in questions
• Largest apparent source of variation is price per HD with independent sector partners
  • Eg for a full service with facilities, nursing staff, labs and HD medications
  • £92 to £174
What didn’t we measure?

- Supportive/Conservative care*
- Detail of OP activity
  - Including novel ways of working
- Research
  - These metrics now available
- Detailed workforce analysis*
  - How comprehensive is your team?
- Clinician contact time in HD
- Pathway documentation*
- Patient information*

*In scope of NHSE QST Peer reviews
Recruitment to NIHR Studies (2017/18 - All Renal Disorders, RADAR excluded)
Peer Assist

• Work in progress
  • Responding to specific requests
• Building a library of good practice
  • Outcomes
  • Innovation
• Relationship with KQuIP
• Network level problems
  • Transplantation
  • Vascular Access
  • Procurement
• Good practice will not always translate to a different geography/setting
GIRFT/UKRR Fellowships

• 1 year funding
  • Clinical Fellow
  • Statistician

• Develop the UKRR-HES Metrics
• Test hypothetical correlations
  • eg low infection and low hospitalisation
  • eg high home therapies and low LD transplantation
• To phenotype the units that succeed
  • eg what are the characteristics of a unit with good VA
Next steps

• Centre visits
• National Report
• Peer Assist
• Refresh the data packs?
  • But too soon to see meaningful change
  • Network packs and data sharing
• Revisits
  • Focussed on one or two areas?
  • Network
    • Transplantation or vascular access
  • Partnership with KQuIP
Questions

william.mckane@sth.nhs.uk