Co-operation and Working Together (CAWT)

Lessons from Northern Ireland

Professor Peter Maxwell
Consultant Nephrologist
Belfast City Hospital
What do we need to do?

• Improve the outcomes for patients
• Educate and train a renal workforce
• Have effective partnerships with primary care to ensure shared vision of chronic kidney disease
• Develop further dialysis capacity
• Improve provision of definitive dialysis access to match best performing units
• Commit to a sustainable rate of transplantation
• Continue the engagement between commissioners and providers of renal services
Networks

- Collegial and inter-professional
- Commissioners and providers
- Patient groups
- HIGH QUALITY INFORMATION
What is driving the Expansion of Renal Services?
Why do kidneys fail?

- Diabetes
- Hypertension
- Glomerulonephritis
  - Polycystic kidney disease
  - Other rarer disorders we spend years learning about
New patients starting RRT 2004 (n=1,992)

**Diabetes**  
20.9%

*Aetiology uncertain*  
19.7%

Glomerulonephritis (biopsy proven)  
12.9%

Polycystic kidney disease  
9.4%

Pyelonephritis  
7.8%
What is happening locally?

• Commissioned research
Patients with HbA1c >6%: 36,137
Creatinine >150 umol/l 3,378
Referred to nephrologist 19%

Diabetes and CKD in Northern Ireland

EVIDENCE BASED PUBLIC HEALTH POLICY AND PRACTICE

Late referral for assessment of renal failure

Frank Kee, Elizabeth A Reaney, A Peter Maxwell, Damian G Fogarty, Gerard Savage, C Christopher Patterson, on behalf of the Northern Ireland TSN Renal Group

Are gatekeepers to renal services referring patients equitably?
Kee F et al. J Health Serv Res Policy 2007; 12: 36-41

“the absolute rate of timely specialist assessment is low”

“opportunities for health gain among patients with declining renal function are being missed, particularly among the old and those living furthest from specialist centres”
Number of Patient on Haemodialysis (NI) and CAPD

- **Newry Unit opens May 1998**
- **New BCH Unit opened Nov 1998**
- **Ulster opens July 2003**
- **Antrim Expansion April 2000**
- **Altnagelvin opens Jan 2006**
- **New Ulster Unit opens Dec 2006**

![Graph showing the number of patients on Haemodialysis and CAPD from 1997 to 2007.](image-url)
Factors influencing the provision of renal replacement therapy

- Significant increase in incidence of ESRD (worldwide and locally)
- ESRD incidence rates largely driven by burden of diabetic nephropathy and hypertensive vascular disease in older patients
- Majority of ESRD patients are not suitable for transplantation
- Kidney donation rates are static
- Improvements in the quality of haemodialysis leads to better patient survival further increasing the stock of dialysis patients
- No clinical or ethical reason to restrict access to RRT on basis of age or diagnosis (except in exceptional circumstances)
- The main determinant of acceptance is quality of life
Reviews of Renal Services
What do we need to do?

• Have effective partnerships with primary care to ensure shared vision of chronic kidney disease
UK General Practice GMS Contract rewards identification of CKD

- eGFR > 90
- eGFR 60-89
- eGFR 30-59
- eGFR 15-29
- eGFR < 15

5% of adults
Locally developed Clinical Guidelines from CREST (Clinical Resource Efficiency Support Team) written by the Northern Ireland Nephrology Forum

Sustained educational effort for

GPs, hospital doctors
Practice nurses
PAMs
Health care students
Persons with CKD

GUIDELINES FOR CHRONIC KIDNEY DISEASE IN NORTHERN IRELAND

Published June 2006
• How will GPs/primary care teams be involved in future CKD management?

• How many persons truly have a “disease”

• What will nephrologists offer CKD patients that is any smarter than good primary care
Low eGFR in older people

natural senescence (physiology)
or pathology?
What do we need to do?

- Improve provision of definitive dialysis access to match best performing units
THE ORGANISATION AND DELIVERY OF THE VASCULAR ACCESS
SERVICE FOR MAINTENANCE HAEMODIALYSIS PATIENTS

AUGUST 2006

REPORT OF A JOINT WORKING PARTY

The Renal Association
founded 1930

C G Winser FRCP (London)
(Chair)
R Fluck FRCP (London)

D C Mitchell FRCS
C P Gibbons FRCS

D Kessel MRCP, FRCR
J G Moss FRCS, FRCR

C A W T

for health gain and social well being in border areas
Percentage of fistula/graft usage Nov 06

- TCH 57%
- DHH 37%
- Altnagelvin 50%
- SGH 45%
- LGH 59%
- Cavan 48%
What do we need to do?

- Continue the engagement between commissioners and providers of renal services
• What will nephrology look like in 10 years time?
• Predominantly hospital-based haemodialysis provision for persons over 70?
Hospital-based haemodialysis is the major mode of RRT.
What do we need to do?

- Improve the outcomes for patients
- Have a shared vision of the way forward
- Strengthen informal and formal networks
- Plan carefully for future demand
- Use information technology properly
- Invest in education
- Implement decisions and audit results