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Remote CKD monitoring as part of a Disease Management Program

By: Sheffield Teaching Hospitals NHS Foundation Trust

Positive outcome(s) of project:

These are still early days but generally patients and staff have responded very positively as people can receive care closer to home without losing touch with secondary care.

Description:

CKD management is predominantly data-driven. Considerable IT infrastructure is already in place that has enabled a remote CKD monitoring service for patients in Sheffield enabling devolved, patient centred care. A future renal database is likely to be able to increase the sophistication of such a disease management program. The start-up costs for such a model mainly consist of a salary for one clinical nurse specialist with modest consultant nephrologist support.

Current model of CKD care in Sheffield

The Sheffield Kidney Institute (SKI) in collaboration with primary care has introduced a number of measures to improve the recognition and management of chronic kidney disease (CKD) in the community whilst ensuring referrals to secondary care are 'managed' in an appropriate way.

These include:

1. Online guidelines covering both the referral and management of CKD in primary care.
2. Online educational package covering the management of CKD in primary care.
3. Allocation of 1 PA of consultant time to screen referrals and advise GPs about which patients can be managed in primary care with appropriate management plans. Since the start of this service in 2006 approximately 30% of referrals from primary care have been dealt with through advice and guidance thereby avoiding unnecessary trips to secondary care. This service meets a key UK Renal Association standard that renal units should provide a non-visit based advisory service for primary care.
4. In addition to the paper-based system above secure, electronic, consultant lead advice and guidance is available to primary through both the Choose and Book system as well through email via an nhs.net account.

Further to these measures, the SKI has identified a group of patients with CKD who currently remain under specialist kidney care but who could be effectively managed in primary care, with specialist support. These are patients with stable/slowly progressive but advanced CKD, who require regular biochemical and blood pressure monitoring, or who require specialist anaemia management.

The problem

Although the number of patients discharged to primary care has increased significantly, discharge rates from secondary care may be limited by concerns about whether patients can be reliably locked into a disease management programme in primary care. Indeed there is data to support such concern. For example the variability in prevalence of CKD by practice within Sheffield PCT ranges between 0% and 9.8%. Whilst some of this variation undoubtedly reflects practice-population demographics it is likely that systems for identifying and monitoring CKD varies between practices. Similarly, only 65% of patients in Sheffield PCT achieved the combined QOF indicators of being on a CKD register *and* attaining target blood pressure.

Proposed model of care

We aim to develop the renal database (Proton) at the Sheffield Kidney Institute (SKI) to allow remote monitoring of patients with CKD. This is being done at the moment with the Sheffield Central Consortium of GP practices.

The key changes we have implemented are:

1. Clinician-led CKD-Disease Management Program (CKD-DMP) specifying frequency of laboratory and blood pressure testing with individualised targets for care.
2. All patients suitable for CKD-DMP to have bloods taken in primary care and self-monitor blood pressure or have blood pressure taken in GP surgeries
3. To utilise a CKD nurse specialist to manage the remote data, liaise with patient and primary care physicians to replace clinic visits with a tele-consultation, reviewing clinical data with patient whilst maintaining care as set out by treatment targets in CKD-DMP.

Which personnel were involved?

CKD specialist nurse and consultant nephrologist in secondary care. Practice nurse in each surgery who acts as CKD link for specialist nurse

What was the timeframe?

Pilot started within 6 months of agreement between primary and secondary care.

Has the initiative been implemented elsewhere, before or since?

Not to our knowledge, though Bradford does have a well developed e-consultation service. This is different, being a remote monitoring and management service for chronic disease.

Sustainability benefits

The introduction of remote monitoring with tele-consultation has the potential to improve the targeting of specialist care resources (financial and environmental) to deliver the maximum value to patients. By involving patients in self-monitoring, the model could potentially enhance patient empowerment in the management of their care, while reducing the need for travel as services are provided closer to home.

Status: ongoing

Implementation costs: No capital costs were required as the lab data already uploads data onto the renal database. Resource required in terms of specialist nurse time, consultant time and practice nurse/GP time

Contact: Dr Arif Khwaja, Consultant nephrologist, Arif.Khwaja@sth.nhs.uk

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Source URL: <https://map.sustainablehealthcare.org.uk/sheffield-teaching-hospitals-nhs-foundation-trust/remote-ckd-monitoring-part-disease-management-prog>