

A national survey of non-face-to-face services for Chronic Kidney Disease in the UK.

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Introduction

The early identification and management of patients with CKD can slow or halt progression and potentially reduce long term morbidity, mortality and costs. Non-face-to-face models of care for CKD are increasingly being introduced in the UK to reduce waiting times for access to nephrologists, enable the earlier detection and management of CKD in primary care and improve clinical outcomes. To date, there is no data on the nature and distribution of such models of care in the UK. We studied the landscape of these services in the UK to inform commissioning and clinical strategy.

Methods

An electronic survey was distributed to all renal Clinical Directors in the UK and completed over August/September 2019. We asked for details of the provision of any non-face-to-face services for CKD, service delivery details and commissioning aspects.

Results

Responses were obtained from 35 of the 72 (49%) renal units over a wide geographic distribution of the UK. Of those responding, 32 (91%) were offering alternatives to outpatient based face-to-face appointments and in many cases units offer more than one type of service. These include - standard NHS advice and guidance through the e-RS system (n=20, 77%), telephone consultations with patients (n=13, 50%), advice based on access to primary care record with no access to GP consultations/letters and no ability to document in the primary care record (n=13, 50%), email advice to GPs (n=10, 38%) and shared, remote access to the full primary care record in which nephrologists can leave entries (n=2, 8%) The majority of these services had been running for between 12 and 24 months. One had been running for a decade.

46% (n=16) of responders had a trigger tool/automated alert in primary care systems to identify patients with rapid progression of CKD. A similar number offered some form of community outreach visits of nephrologists and/or nurses into primary care settings for teaching and MDTs.

Nineteen, (73%) of these new models of care had a contract with commissioners. There were a variety of funding models, with some units obtaining reimbursement from more than one source. 52% (n=14) were funded by the national advice and guidance tariff, 33% (n=9) had a block contract whilst 22% (n=6) were unfunded

Only one of the services had undertaken a formal cost-benefit analysis, with two completing a rough costing exercise.

Of those not running alternative models of care 25 (67%) intend to do so, with half of these expecting to do so within six months, the remainder planning on doing so within a year.

Conclusions

There are a wide variety of new-models of care in the UK for patients with CKD, operating at a range of maturity with a variety of funding mechanisms.

These services will require appropriate methods of reimbursement and economic analysis if they are to remain sustainable and deliver high quality, cost effective care. Currently there is no consistent funding model with many services receiving no reimbursement. National guidance on commissioning and delivering such services from key stakeholders will help promote sustainability, efficacy and growth.