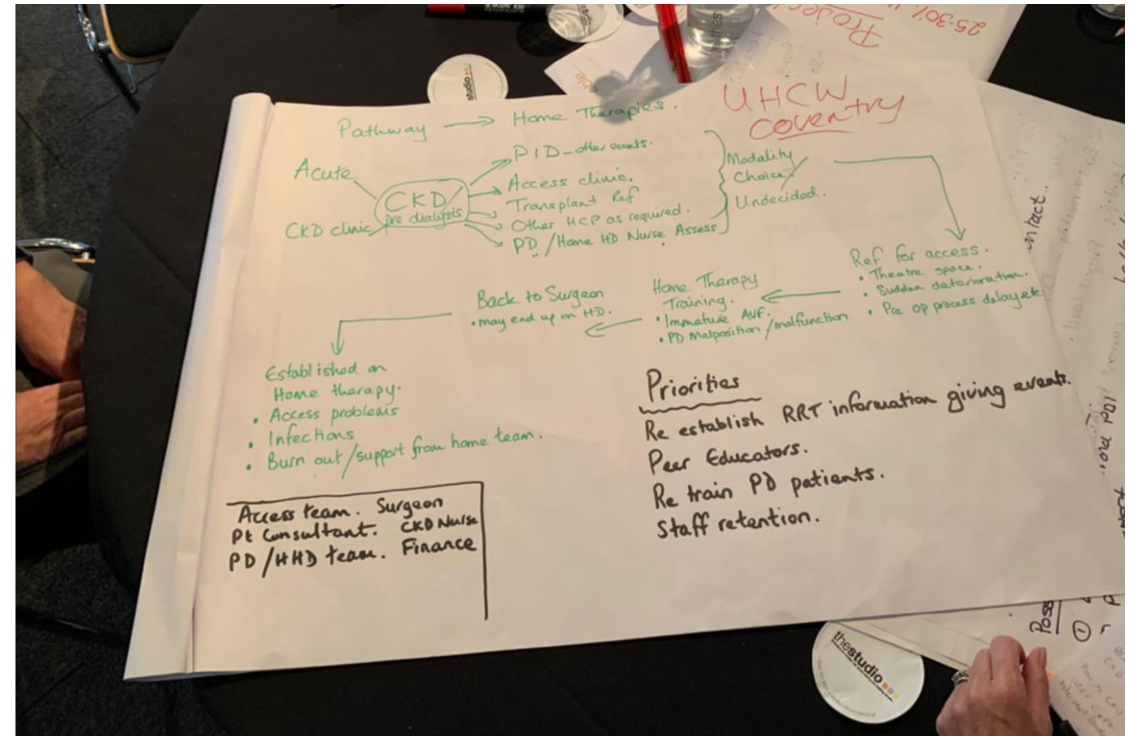
Coventry

Would like to achieve 25% prevalent dialysis patients to be receiving dialysis at home in two years

Reflections on pandemic

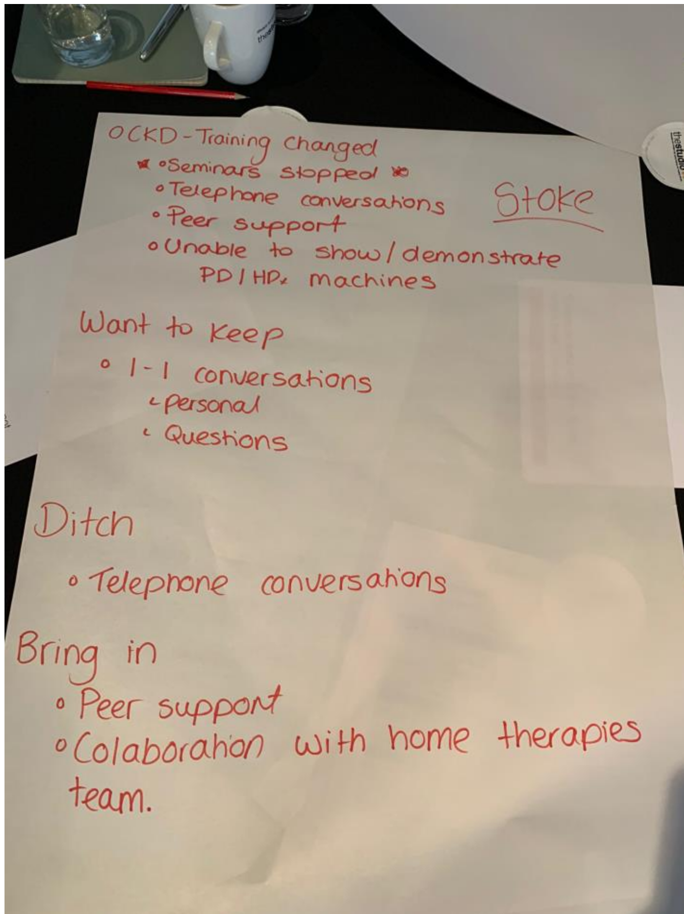
Action planning



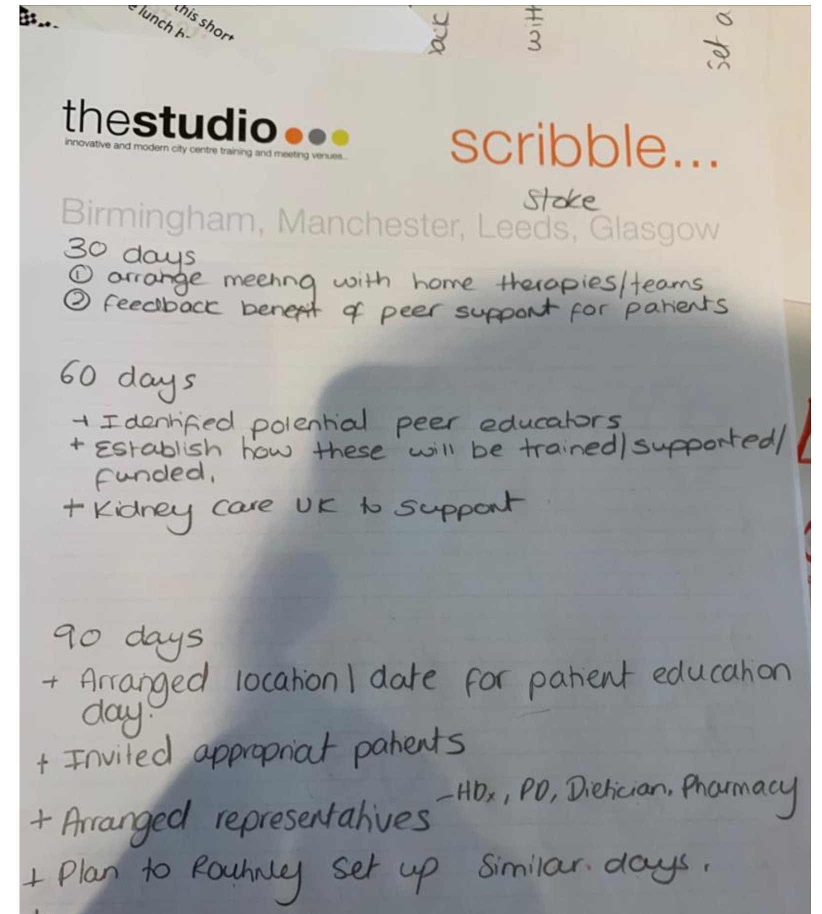
Stoke

Would like to achieve 25% prevalent dialysis patients to be receiving dialysis at home

Reflections on pandemic



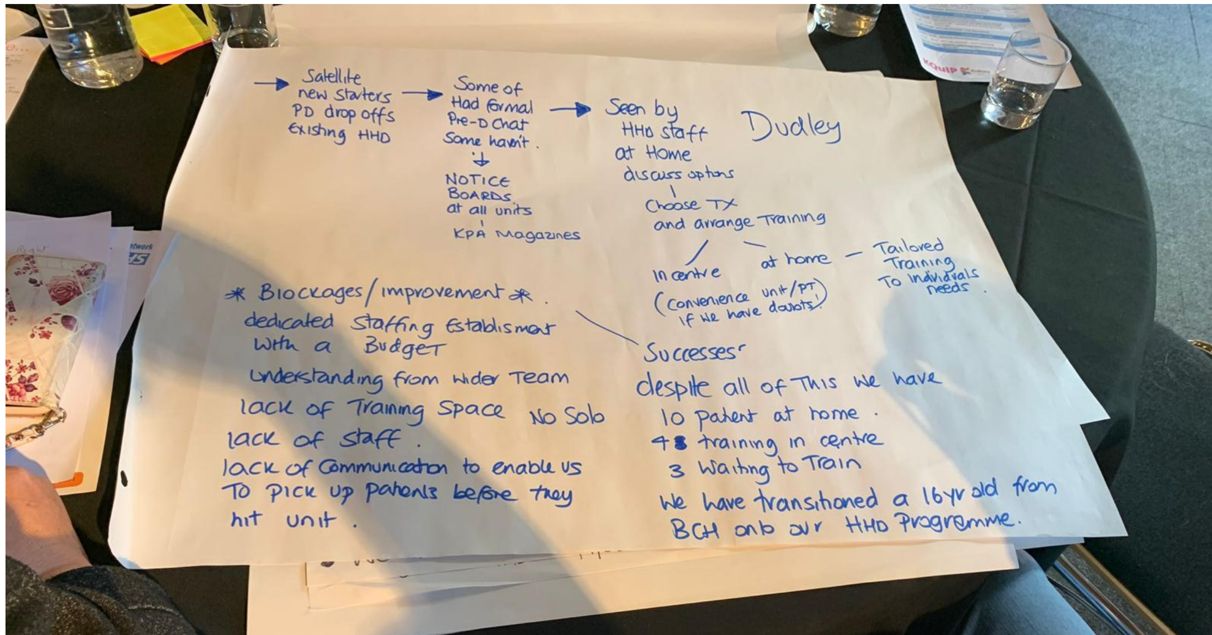
Action planning



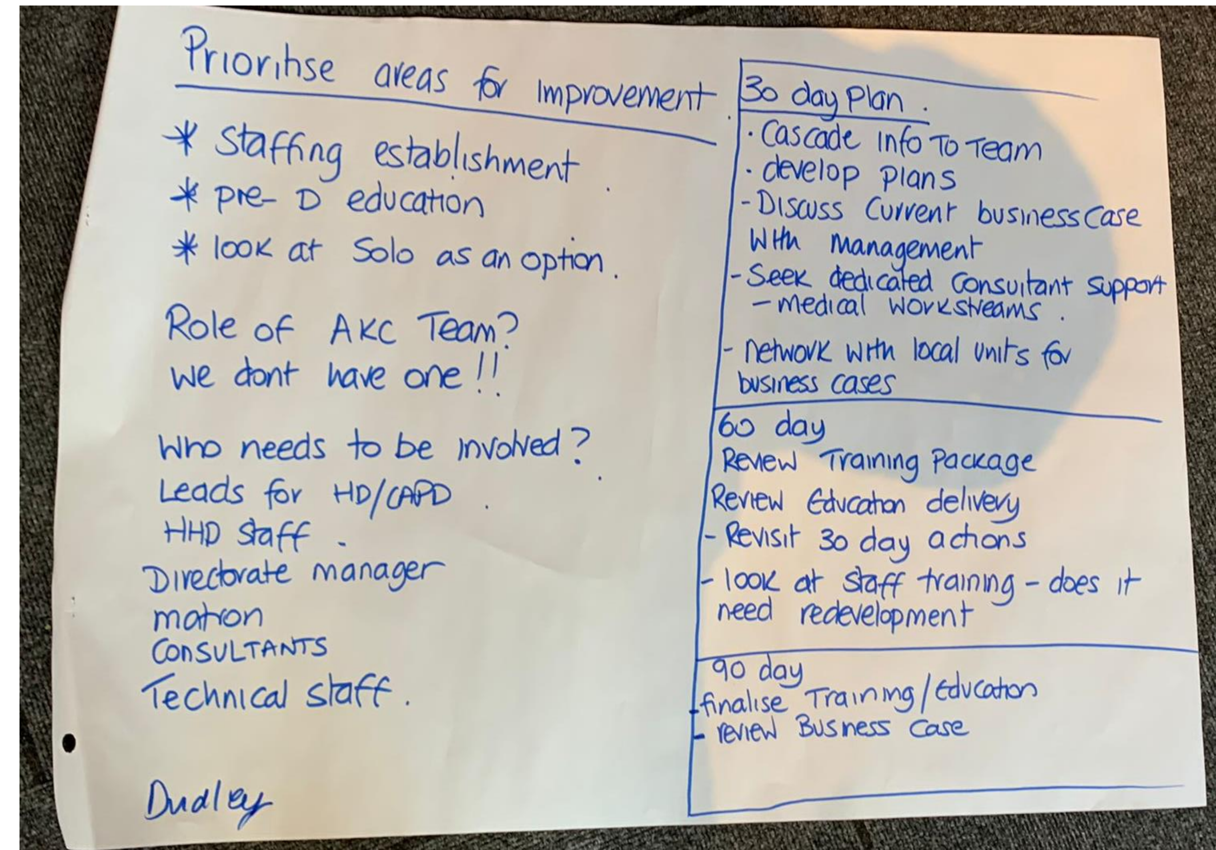
Dudley

Would like to achieve 20% prevalent dialysis patients to be receiving dialysis at home by Spring 2024

Reflections on pandemic



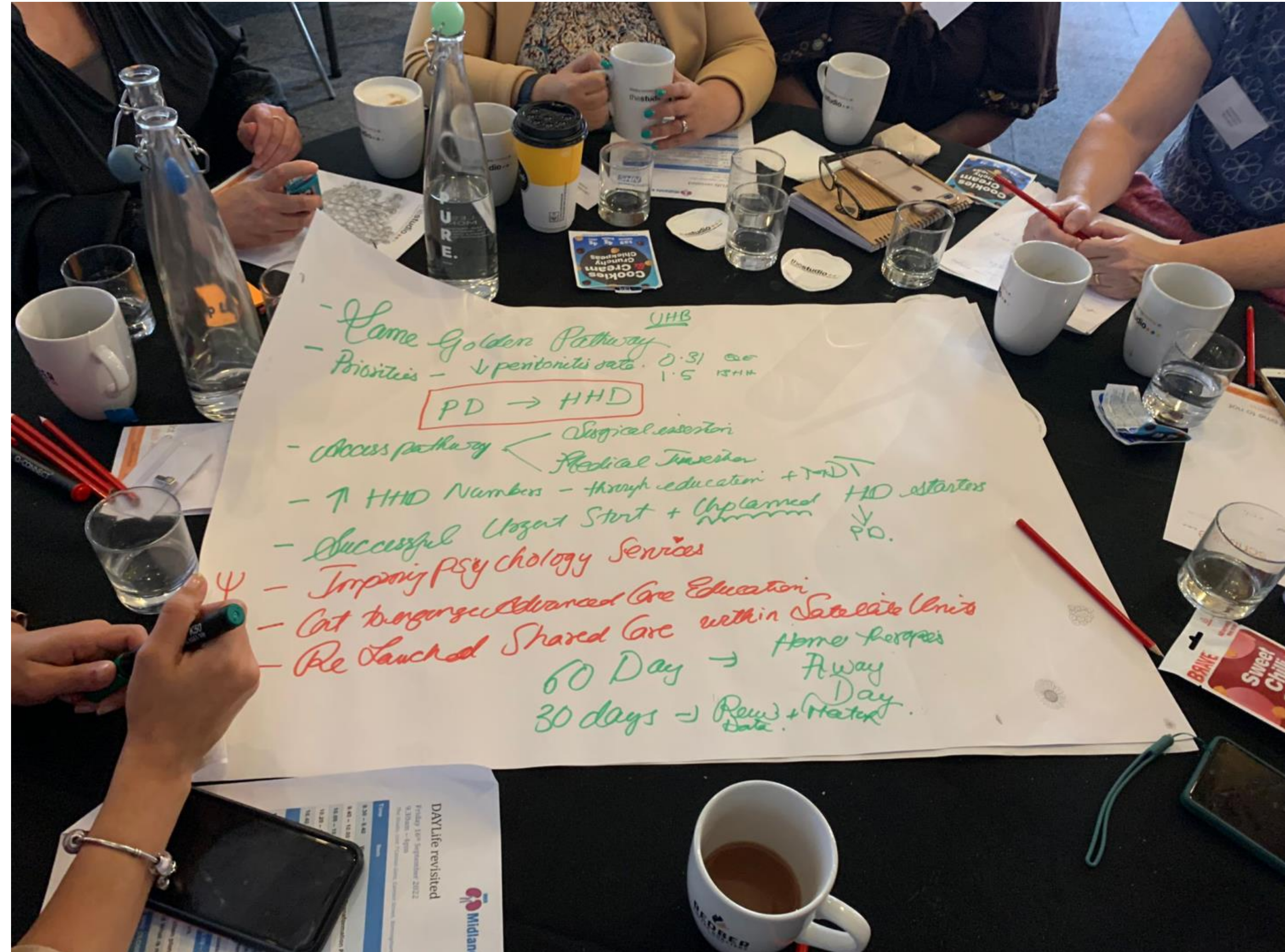
Action planning



University Hospitals Birmingham

Would like to achieve 22-25% prevalent dialysis patients to be receiving dialysis at home in 18 months

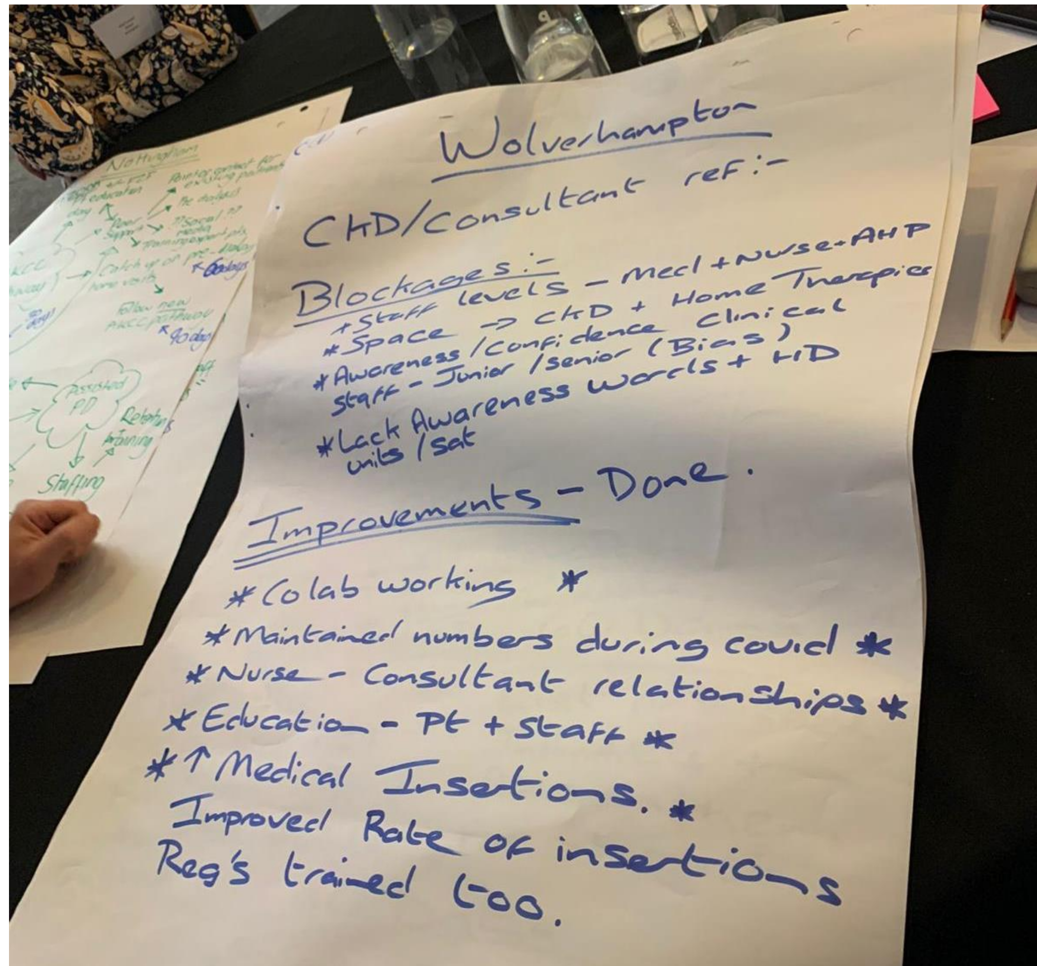
Action planning

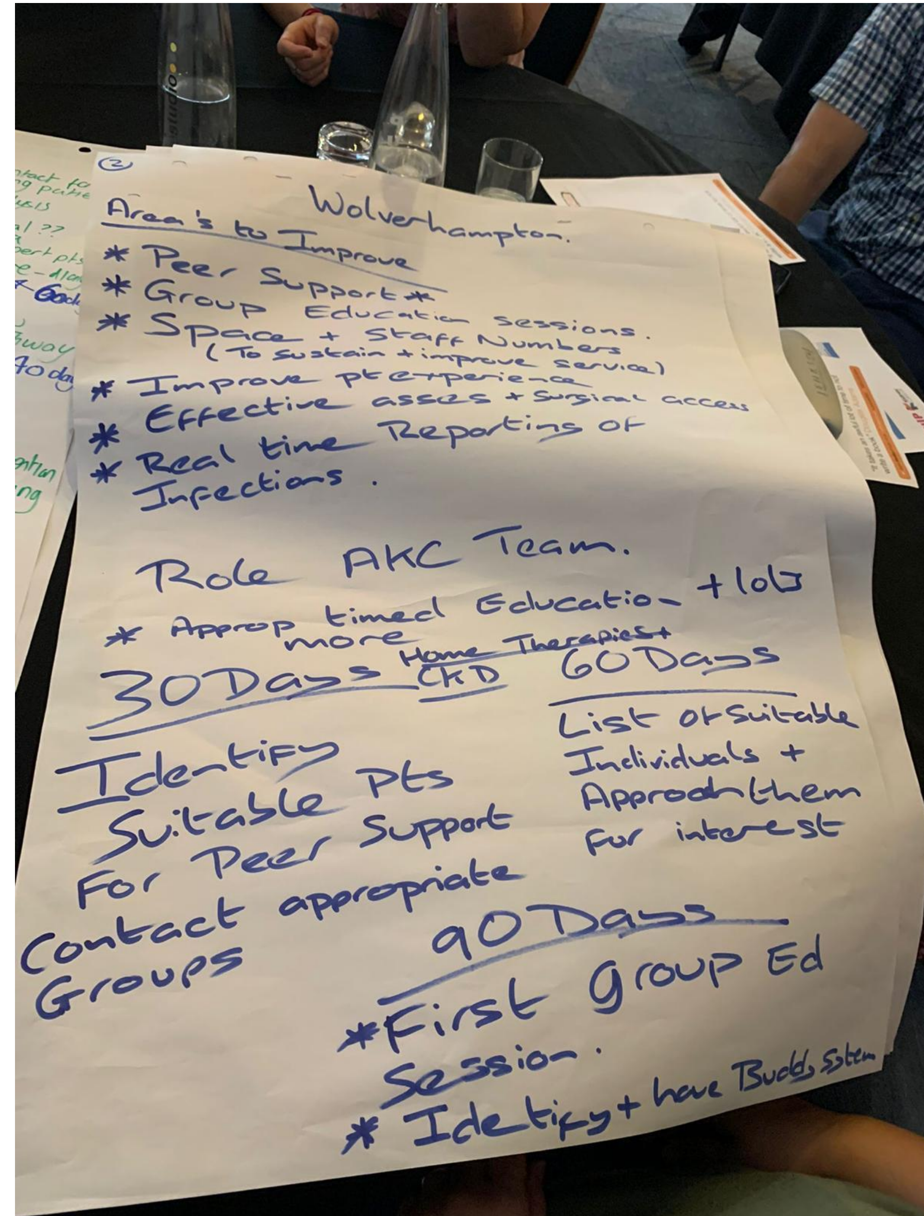


Wolverhampton

Would like to achieve 25-30% prevalent dialysis patients to be receiving dialysis at home in two years

Action planning





Leicester network

Would like to achieve 85% patients starting on choice of therapy by the end of 2023

Action planning

Leicester Network.

Possible projects:

~ Standardization across Network
- ↳ Exit site care.
- PD clinic set
- Ref for PD catheters
- Each area putting in own tubes.
- Reducing No of primary non functioning catheters.
- Pre dialysis education.

Person Project Leads – to engage engagement across network.

Action Plan. for Lincoln to Reintroduce Patient info Days.

30 days ~ 60 days. + 90 days.

< Band 7 meeting – Discuss standardisation – .

Identify Project Lead. – specific areas to focus on.

Pre Dialysis Education. – current pathway.

Ref's from Nephrologist to RCT → GFR. 20–10. → Triage → Book HIV Tel. consult Unit visit. → option.

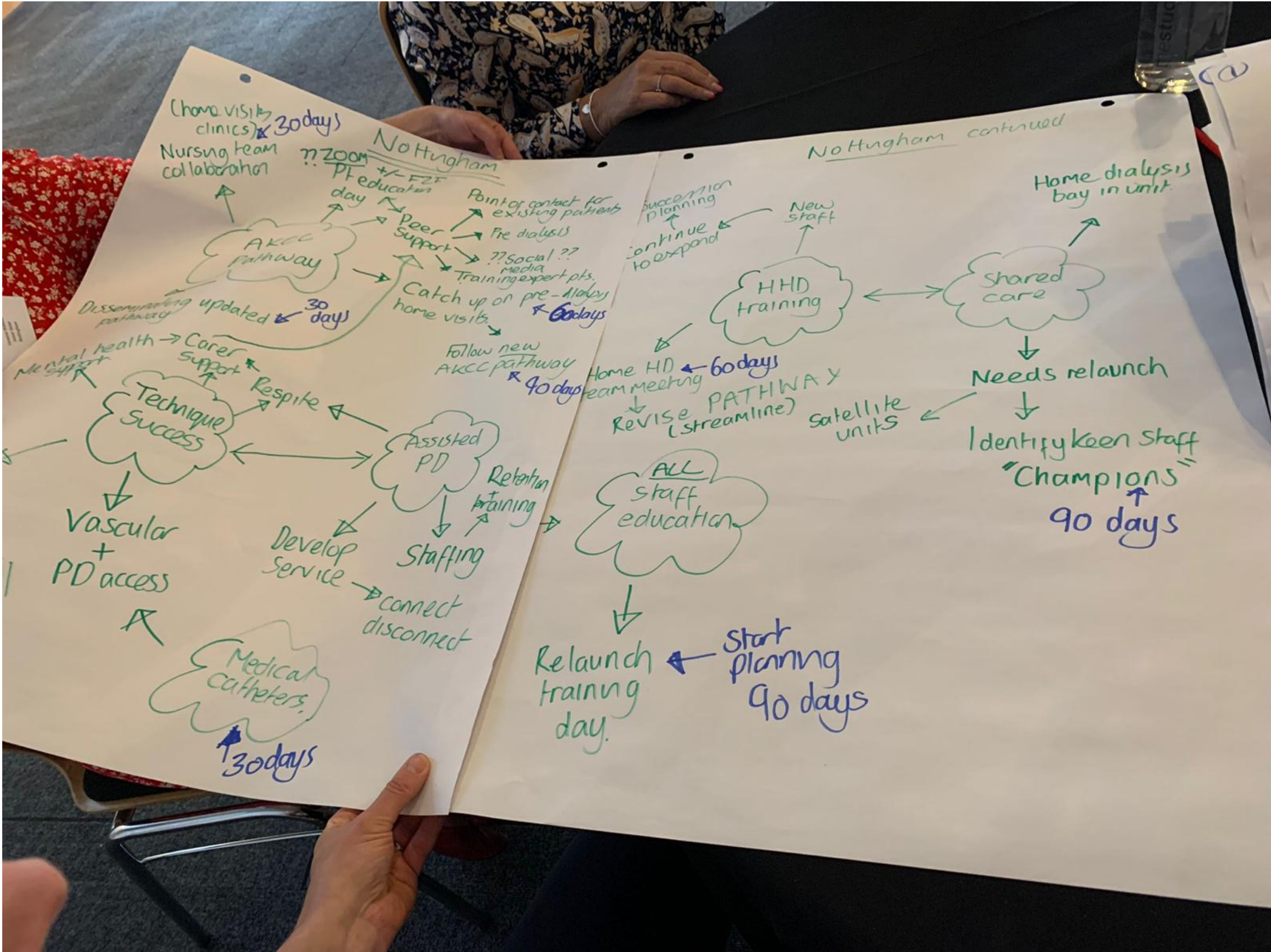
Wish list: standardise across network.

Formulize Ref Process.
- ↳ E-Ref to community team.
- ↳ offer PID. Involve Dietitian / Pharmacist / Peer Support / Kidney Pt Association
- ↳ Home visit – to feed to PID.
- ↳ Digital Aids / Education.
- ↳ E-feed back form.

Nottingham

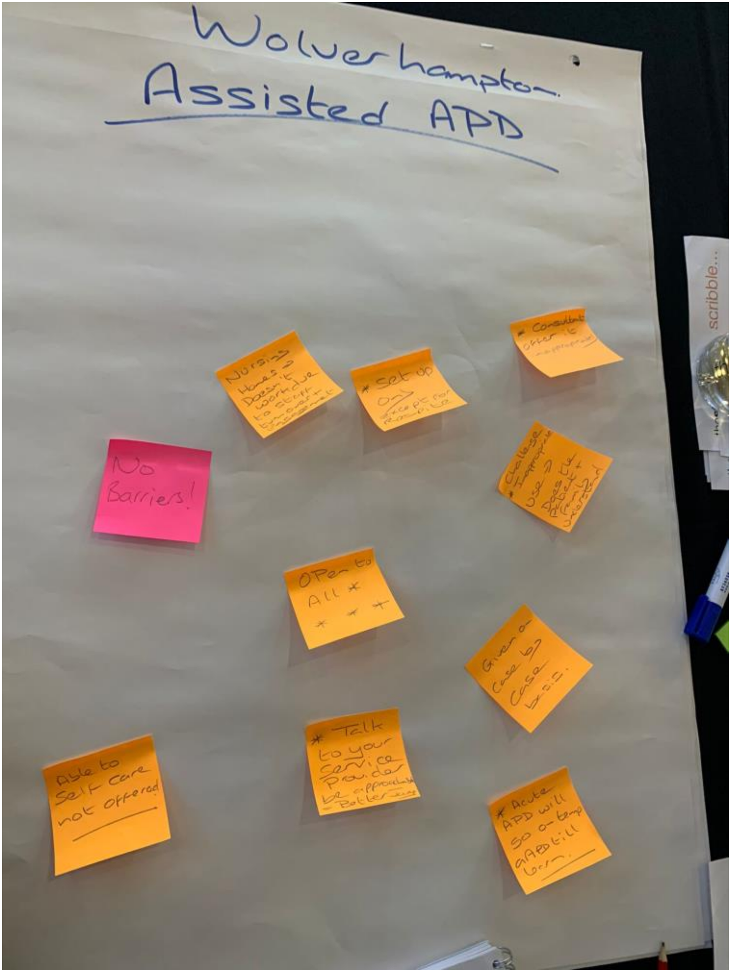
Would like to achieve 30% prevalent dialysis patients to be receiving dialysis at home in three years

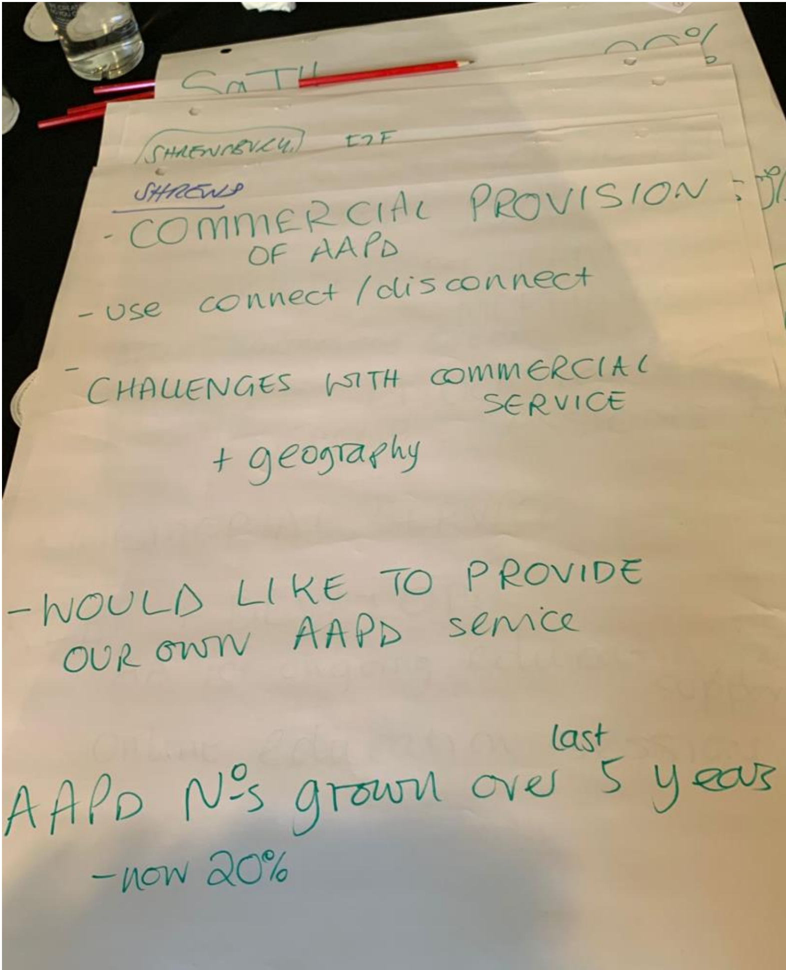
Action planning



Assisted PD

- How do you use the assisted PD service?
- What assistance do people need?
- What are the challenges in offering assisted PD?
- How would you like to use assisted PD if challenges were overcome?





Assisted PD

① - Allows frail / Disabilities to have a home therapy - lack of support at home / live alone

② Gives confidence / support - keep pts at home

+ physical / emotional

③ Challanges
+ Staffing
+ Geographical
+ Reliance on external for connect / disconnect
↳ Try and make in house

④ Changing service - not 9-5-M-F 24/7

STOKE

Leicester 0
Peterborgh 9 (4 set up & connect)
Lincoln 10 set up only.
Northants 9 set up only

All Bionical. Mostly frail, occasionally for low volume staff until trained. Can support longer training time if needed.

Challenges - geographical areas. Reliability of staffing. Communication. Pressure on community senior staff re phone calls out of hours. Late night visits / Errors

Positives. dedicated staff from Bionical enables frail pts to stay at home.

Aiming for in house / hybrid provision to use to enable acute start PD.

Challenge
- Switch to physioneal.

UHCW

In house = Limited capacity - staff + geographical catchment
- issues with external providers

* Set up - patients connect

* Challenges = offering service due to capacity
= pre dialysis option.

* Larger service - offer respite
take on longer term patients

* pt in centre due to lack of staff for AAPD.

AAPD

IN HOUSE / B

USE:
- as needed Frailty → xyz
- Training
- Urgent Start PD
- Respite
- Temporary / Training

Assistance:-
- physical
- setting up
- C&D (Bionical)
- poor confidence
- longer training required

Challenges:
- Staffing < retaining / recruiting.
- Cost.
- Geography.
- Weather
- Comfort / lack of independence
- Understanding
- Contract.
- No assisted CAPD
- Accommodation.