

AKC Service Overview – SaTH

Julie Oliver – Lead CKD Specialist Nurse

Elaine Gibson – PD Specialist Nurse

AKC Team Structure



Shropshire, Telford and Wrekin
Community and Hospitals
NHS Group

1.0 WTE Band 7 Specialist Nurse (Independent Prescriber)

3.0 WTE Band 6 Specialist Nurses (Independent Prescribers)

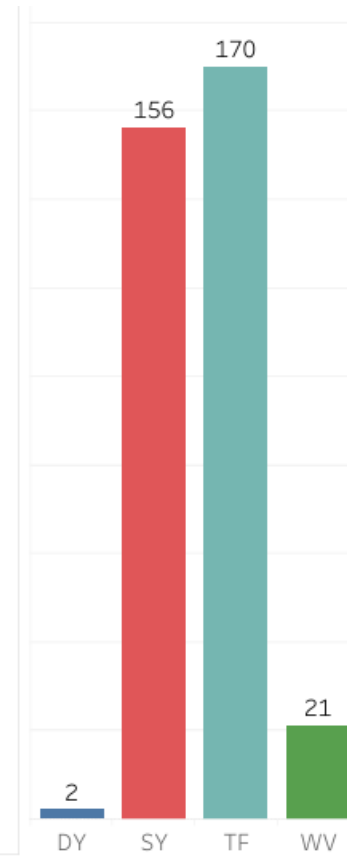
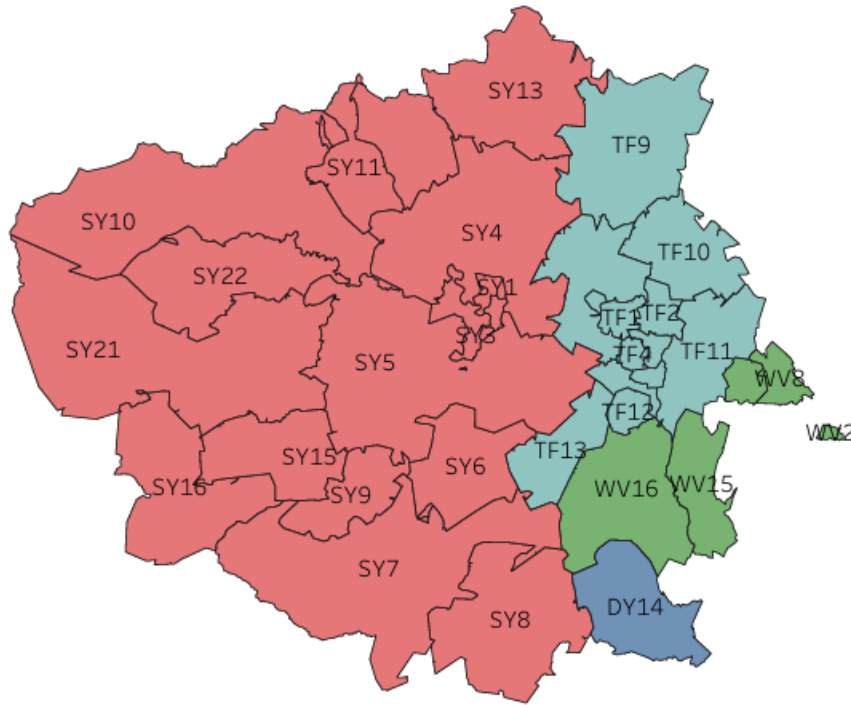
0.6 WTE Administrative Assistant

All staff with >10 years' renal experience (50% PD / 50% HD)

Provide CKD education, renal anaemia management and supportive care.

349 patients with an egfr <18 155 patients on ESA





Focus: eGFR <18 ml/min

Referrals from inpatient teams and general nephrology clinics

Patients fed into AKCC (4 consultants; 1 clinic/month each)

Home visit

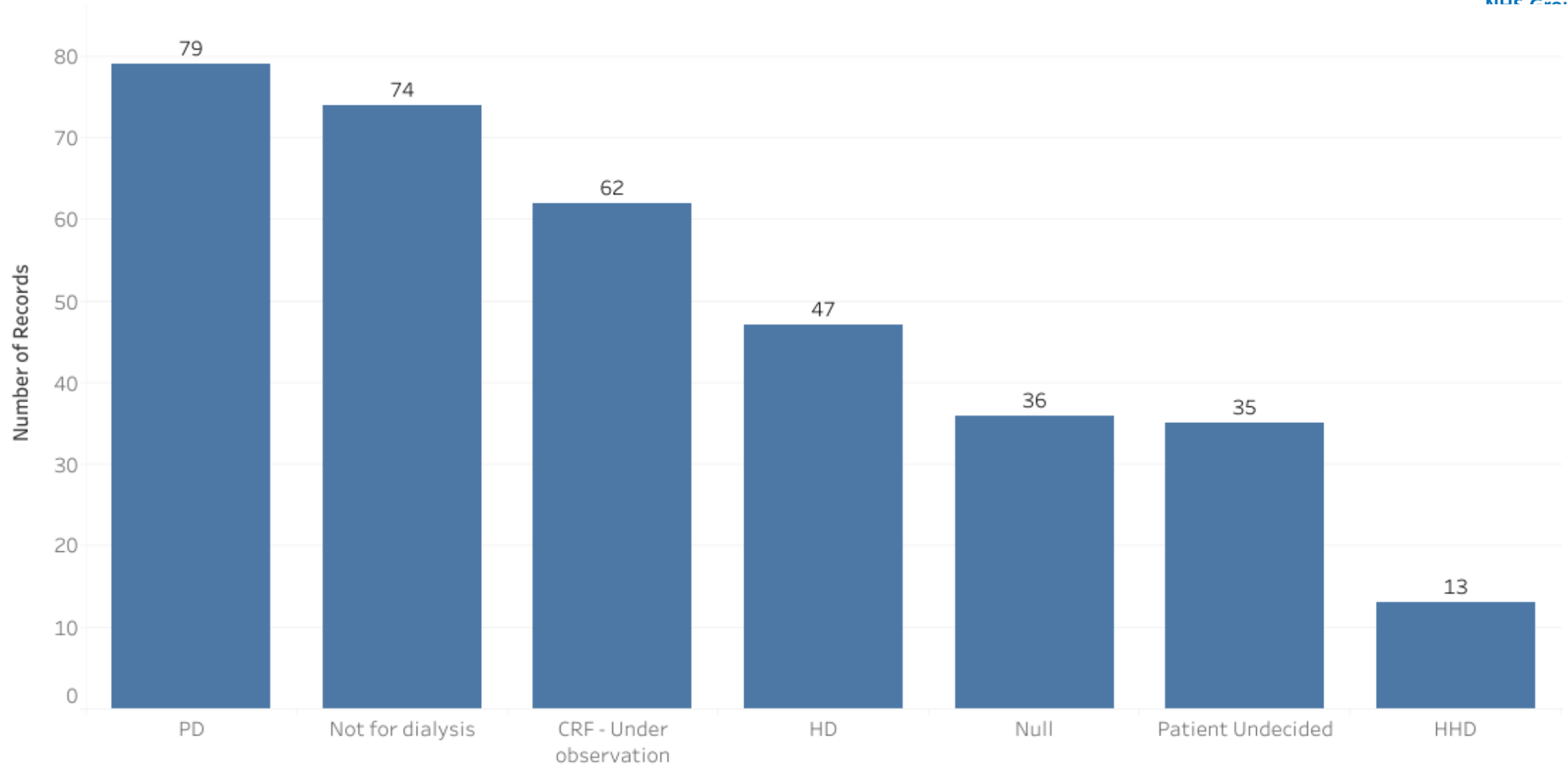
Treatment-options seminar with patient representative (includes transplantation)

Home Therapies Fayre (HHD and PD patients demonstrating therapies)

Ongoing telephone support: fluid assessment, BP monitoring, symptom management, admission avoidance

Monitoring and ordering blood tests

Database tracking: dialysis decisions, immunisation status, transplant status



CKD Education & Preparation

Home-based education on kidney function, progression, and treatment options

Shared decision-making with family/friends

Patient Knows Best enrolment

ReSPECT discussion introduced early

Hepatitis B immunisation counselling

Peer-support offered

When eGFR Deteriorates

Referral to Vascular Access Team for AVF at eGFR ~12

PD abdominal assessment clinic (medical/surgical insertion pathways)

Surgical PD insertion prioritised

Referral to HHD team for home assessment

HD preparation: unit tour

PD preparation: home visit, swabs, bowel prep, equipment planning

Conservative Management pathway discussed

Monthly MDT Meetings



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Low Clearance QA meeting

Anaemia MDT

Supportive Care MDT with hospice team



Clinic Activity

4 AKCC per month with consultants

PD abdominal assessment clinic (bi-monthly)

Nurse-led Hepatitis B clinics (fortnightly)

Nurse-led outpatient service (Mon-Fri 8am-5pm):

- Education
- Blood tests
- Review of patients of concern
- EPO and IV iron administration/teaching

Conservative Management / Supportive Care



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Close collaboration with hospice, bi-monthly meetings

Referral when approaching end of life or when symptom advice required

Timely hospice referral; joint visits for complex cases

ReSPECT documentation completed

Advance care planning offered

Communication with GP/DN



Service Strengths

Experienced staff able to overcome barriers to home therapies

Strong links with vascular access, surgical teams and hospice

Ability to provide medical and surgical PD catheter insertions

Informatics used to identify patients needing further education or AKCC referral

Focus on patients with eGFR <18 — achievable with current staffing

Patient representation at education events

Continuous education with renal team medics/nurses regarding home therapy options

Stable, cohesive team with shared vision and goals

PD and HHD Teams

- Provide **structured training and re-training** to reinforce safe technique
- Conduct **community/home visits** to observe technique and identify infection risks early
- Offer **24-hour clinical support** for PD
- Monitor for **technique drift**, equipment challenges, and patient confidence gaps
- Implement **early intervention pathways** for suspected infections or complications
- Review **unplanned starters** who began in-centre haemodialysis to reassess suitability for home therapies
- Address barriers such as **education gaps, social support, housing, and confidence**

Patient A

55 year old male with progressive multi-focal leukoencephalopathy

Limited mobility, wheelchair user can transfer and shower independently

Lives alone with no family/friend support (has a carer once daily)

Uses an ipad to communicate as cannot speak

Patient B

43 year old Type 1 diabetes

Previous PD needing transition to HD due to fluid problems prior to transplant

Failed kidney/pancreas transplant

Blind

Epilepsy

Eczema

Patient desire to return to PD

Patient C

34 year old male

Type 1 diabetes

Autism Spectrum Disorder (Asperger syndrome)

CVA/TIA

Substance misuse (current cannabis use)

Lives alone with mother's support

Aggressive dog

Refuses HD



Tea break



Second interactive workshop 14.45– 15.35

<p>How people make choices/ shared decision-making Room: Connect (floor 4) Dr Anna Winterbottom Dr Jyoti Baharani</p>	<p>Smooth transition onto home dialysis Room: Develop (floor 3) Dr Mark Lambie Julie Oliver & Elaine Gibson</p>	<p>Transplant workup pathways - new BTS guideline for cardiac assessment Room: Innovate (Main Room, floor 3) Prof Adnan Sharif Dr Shivanand Chavan</p>
<p>Psychosocial care in AKC Room: Achieve (floor 3) Dr Janette Moran</p>	<p>Improving quality of life with symptom management Room: Room: Escape (floor 4) Dr Kathrine Parker Prof. Helen Hurst</p>	

Grab a coffee and check out the industry room – Room BOND 4th Floor

Third interactive workshop 15.35– 16.25

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