

# Review of London kidney teams' response to COVID-19, March-June 2020

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## 1. Introduction

More than 180 people came together via teams to review the response of renal teams across London to the first surge of COVID-19 pandemic in the UK. Attendees included patients, doctors, nurses, allied health professionals, commissioners and managers.

This is a summary report which should be read in conjunction with slides from the day (*please see page 13*) and other national guidance. The discussion from the day was also fed into a report produced by Smeeta Sinha and Clara Day on behalf of NHS England. The recommendations from that report - looking specifically at learning from renal involvement in critical care are copied separately below, (Appendix 1), and so are not generally duplicated in reported themes.

Broad themes from the day are followed by the key themes discussed in each session, with more detailed capture of the discussion for each session following.

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## 2. Broad themes

The day recognised the unprecedented burden of work placed on kidney teams and their fantastic response. There was collaboration both across multi-professional, multidisciplinary renal teams and in conjunction with other teams, notably in intensive care.

A persistent theme was the struggle to provide consistent high quality patient information, advice, counselling, and consent in the context of marked uncertainty and rapidly changing national guidance. Much discussion revolved around ways of using our combined expertise and capacity to provide better, more consistent information for patients.

Equity of access and outcome was another recurrent theme. We know that the impact on BAME groups (both patients and staff) was disproportionately high. The role of social deprivation was highlighted.

The benefits of collaboration and the opportunities around data sharing and analysis, joint approaches to training, sharing of ideas and resources were common positive refrains.

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## 3. Next steps

The report does not make definitive recommendations for action but highlights the outcomes of discussions held on the day. Within each theme a number of next steps have been identified which should be considered and developed further by the stakeholders in the London renal networks.

#### 4. Key themes from each session

### Protecting people on in-centre haemodialysis (IHD)

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#### Patient support, advice and information – ‘let’s turn our faces to the front door’

- Meeting and greeting patients is simple but effective
- How can we ‘walk with’ patients better through their journey: explore options for named nurses or case managers
- Choice (and information to support it) is ever more important - for example, the communication of risk associated with in-centre haemodialysis, and provision of pathways to facilitate home therapies or supportive care where chosen.
- Advanced care planning and frailty assessments are essential and should be part of routine care and conversations with patients
- There is an opportunity to improve patient information across London so that it is consistent, accessible and embraces technology, ideally through one repository
- Wellbeing support for both patients and staff is vital

#### Infection control

- A variety of approaches to segregation and isolation were implemented across London but there was no clear signal that one isolation strategy was more effective
- Expansion and availability of home therapies as a treatment option can help to minimise risk
- Provision of a transport hub with regular sharing of information about capacity, dynamic learning, and guidance reduced enabled units to balance the risk of missed dialysis sessions against the need to optimise infection control

**Collaboration and sharing of workforce** within services and across services with rapid onsite training and refresher courses was vital

#### Potential next steps

- Use the London Networks to review workforce and consider a contingency approach to maintain renal services during a second surge
- Use the London Networks to convene a London patient information group with appropriate stakeholders
- Explore the meet and greet concept used during COVID-19, considering named clinicians, care navigators or case managers

## Renal teams supporting AKI in the critically ill patient

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- Training of ITU teams – develop shared resources and experience across London in the training and education of renal and intensive care teams to support renal replacement therapy for critically ill patients.
- Consider having a named renal consultant present in ITU for peak surge periods to improve communications and support teamwork and shared learning.
- Continue to share the diverse approaches across London to help meet the needs of patients with specific RRT requirements (such as PD where coagulopathy renders vascular access very difficult).
- We achieved good outcomes in some kidney patients using innovative solutions. How do we evaluate these for use in the future?
- Intermittent haemodialysis was an option for ongoing HD care in place of CRRT.
- Kidney teams can collaborate with critical care teams to minimise risk of acute kidney injury and avoid starting renal replacement therapy sooner than is necessary or beneficial.

### Potential next steps

- Use the London Networks to develop a pan-London ITU/Renal nurse group to support a sustainable training model to maintain skills. Potential to involve industry in the delivery of this.
- Share learning between ITU and renal networks and ensure closer collaboration and joint planning for second surges
- Collate outcome (PD, CRRT, IHD in AKI) and histopathology data, and share analysis and findings to inform future planning

## Remote working in Nephrology

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- Ensure IT infrastructure and space to enable confidential remote consultations
- Record consultations and use for training and educational purposes
- Use Attend Anywhere to provide opportunities for joined up working involving the MDT, family and carers
- Consider evening and weekend remote consultations from home providing a flexible approach
- Develop education programmes and information for patients to enable a good remote consultation
- Promote patient activation and self-management

### Potential next steps

- Use the London Networks to develop consensus on remote working
- Hold a follow up event to define best practice and review progress

## Restarting Vascular Access and Transplantation Safely

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- Review local and national shielding guidance, and current practice, and establish a consistent approach across London for before and after surgery
- Continue pan-London collaborative work for both vascular access and transplantation to inform and coordinate surgery re-start, and follow through with pathway quality improvements
- Develop opportunities for improving data sharing and analysis, particularly for vascular access waiting times management and improvement plans
- Consider joint approach to surgical training
- Share further information to promote consistency on patient information, advice helpline, counselling and consent
- Make clear pan-London plans to assure the continuation of vascular access and transplant surgery during resurgence or second wave pressures
- Develop plans for more resilient and assured vascular access service including consideration of ring-fenced cold site activity to protect capacity and flow
- Re-start collaborative work on transplant work-up, unifying pathways, clearing backlog and think about 'investigation centres'
- Consider how to optimise swabbing of pre-emptive transplant patients

### Potential next steps

- Review local and national shielding guidance, and current practice, and establish a consistent approach across London for pre and post-surgery
- Develop and continue with vascular access pan-London collaborative working
- Working pan- London, standardise the deceased and living donor kidney transplant work-up pathways e.g. cardiac diagnostic tests
- Develop the concept of mutual aid to accommodate the potential need for local plans to be curtailed again in a resurgence or a second surge

## Appendix 1

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### Summary of discussion

#### Protecting people on in-centre haemodialysis (ICHHD)

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##### What worked well?

- A variety of approaches to segregation and isolation were implemented across London; there was no clear signal that one isolation strategy was more effective than others
- Clinical leadership and collaboration across the whole of London with mutual support
- Collaboration and sharing of workforce within services and across services with rapid onsite training and refresher courses—medical students, dentists, surgeons, dieticians, pharmacists provided full support to dialysis patients
- Meet and Greet triage of all patients provided a welcome and reassurance from staff
- Patient HELPLINE provided in various forms by telephone or email provided access to information regarding treatment options during COVID-19 allowing signposting and triage of a spectrum of patient issues raised during COVID-19 as a result of changes in ordinary processes
- Kidney Care UK website provided timely high quality accessible patient information
- Transport Hub—to share regular capacity information and create pan-London guidance
- Active engagement and support of all staff, either sick or shielding, by senior leadership teams either by face-to-face visits or regular phone calls
- Promotion or expansion of home therapies programmes as a treatment option to minimise risk
- Written communication to all patients to maintain updates on the latest guidance.
- Trust websites hosting key information with useful links for patients
- Scripted information for teams to communicate to patients for consistency and clarity
- Renal dietitians were placed in some satellite units to support with diet/fluid management for patients on reduced hours/twice weekly dialysis



### Key challenges

- Protecting patients on ICHD ensuring all 12 themes are met in such a short time frame
- Protect patients by protecting staff - maintain a resilient workforce
- Maintaining consistent and updated communication with patients and families
- Strategies to maintain communication with families and loved ones of patients unable to communicate during an inpatient stay
- Providing clear and accessible patient information in the face of constantly changing NHSE/government communications to the whole population rather than considering specific groups of people with particular risk factors
- How to embed advanced care planning in care pathways at the right time to reflect the long-term teams knowledge of the patient and families wishes
- How do we maintain HD skills in qualified HD staff who move to work in other renal specialist clinical areas such as transplant or dialysis preparation and ITU to redeploy quickly during a second surge
- Maintain a workforce in all treatment areas such as transplantation, low clearance, home therapies and vascular access
- Ensuring equity and equality of access to all patients to treatment options and decision making
- Consistent transport guidance was lacking during the surge

### What could we do better?

- Maintain renal nursing expertise in HD and PD
- Maintain and assure equity of access to other services such as low clearance, supportive care, transplant and vascular access
- Communication with patients and carers, especially if an inpatient; consider examples of good practice like a daily telephone update
- Provide more comprehensive wellbeing support for patients and staff
- Providing better peer support – access to other patients' experiences and sharing of information - active peer supporting in the young adult patient community throughout this time has helped both with practical but also psychological challenges that people have faced
- Easily accessible information using technology to enable equity of access for the hard of hearing, partially sighted, other disabilities and for those who are hard to reach.
- Escalation plans on, or prior to, admission— using validated frailty tools and Advanced Care Planning to facilitate conversations and prepare patients and families for these decisions
- Improve patient information: Keep It Short and Simple (KISS). Explain all technical language and make sure it's read and sense checked by a wide range of patients

## Renal teams supporting AKI in the critically ill patient

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### What worked well?

- Collaboration between Nephrologists and Intensivists was vital to meet the unpredicted demand for RRT on ICU
- Different units found different solutions (e.g. IHD, APD, making fluids for CVVHD) all of which had merit and drawbacks
- The practical expertise of the technicians was vital in planning and delivering and expanding RRT at pace in ICU. The use of portable RO units was an essential part of this
- Sector level critical care and renal collaborations were vital for active movement of patients and provision of care
- Pan London collection of data and sharing of wider information was also essential, not least to allow the movement of patients between sectors when needed
- Local efforts by renal teams to establish alternatives to filtration within their own trusts were essential
- Accelerated training nursing plans in working with ITU colleagues enabled teams to deliver IHD
- ITU teams found that having a named renal consultant shared learning and improved communication and teamwork
- There was fantastic work from Renal technicians to get necessary work done to facilitate RRT expansion

### Key challenges:

- Working at such a pace for a sustained period was challenging
- There were different levels of network functioning and functional groups depending on purpose: clarity on each of these roles only emerged after some weeks and with some avoidable duplication of effort
- Managing the practicalities of installing water, rapidly expanding PD, sustaining workforce, and providing training
- Burden on staff, especially dialysis nurses, to provide renal support in ITU whilst also maintaining staffing for ICHD units

### What could we do better?

- Improve decision-making and communication with patients and families regarding treatment escalation plans
- Capitalise on the opportunity to continue the improved management of AKI through structured and ongoing closer collaboration between renal and ITU teams
- Clearer transfer protocols covering escalation of patients in non-renal centres

## Remote working in Nephrology

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### What worked well?

- Community phlebotomy services in some areas helped patients stay away from hospital and worked well with remote consultations
- Flexible working and working from home for clinical staff helps to maintain a better work-life balance
- Convenience of evening clinics appreciated by some patients and clinical staff
- Attend Anywhere works well, is easy to use and helps improve MDT working and patient access e.g. family members invited to join consultation, possibly for translation
- Remote working can promote self-management by patients (if appropriately resourced)
- Telephone clinics proved relatively easy to set up
- Trusts experienced lower rates of DNA – may be a function of lockdown
- Our experiences will inform the rapidly developing science around selection of appropriate consultation setting, which will inform future practice
- The speed of implementation and roll-out demonstrated a new model for working at pace
- Remote working has created the need for innovation in the pathways e.g. excellent advice sheets/resource were developed and used for ward teams for breaking bad news over phone
- Those clinicians who had experience of both telephone and video clinics in general found telephone to be less good, if more easily accessible to all

### Key challenges

- Hospital based phlebotomy does not fit well with remote working – in particular during the peak of the pandemic, many patients were fearful of coming to the main hospital for venepuncture
- We do not yet have the infrastructure in place to enable blood results to consistently be relayed back to clinical teams
- Setting up and administrating remote clinics required huge administration support as well as clinical time to work through patient lists
- Preparation and triaging patients for clinic needs dedicated time
- Available space to hold a telemedicine clinic and the necessary software and hardware (headphones and web-cams) were not in place to start with
- Concerns about equity of access to remote consultations and not meeting the needs of certain patient groups
- At present we do not have a complete understanding of what aspects of care can be delivered effectively in a remote clinic

### Key challenges continued

- Breaking bad news by telephone is very challenging, but can work with system changes such as clear written protocols, scheduling a follow-up call, and identifying a dedicated contact person in the renal team
- Forming and maintaining a doctor-patient relationship in a non-face to face is important
- Efforts need to be made to be holistic in a telemedicine setting. Video consultation platforms such as Attend Anywhere allow for up to 6 participants to take part in a consultation and so with the right resourcing it is possible to continue to provide multi-professional input in a telemedicine clinic
- Telemedicine clinics have the potential to both lose and gain training and educational opportunities for trainees. Clinicians will need to be imaginative in the way they approach training in non-face to face settings
- Telemedicine clinics are not intended to fully replace face to face consultations. There is a need to provide a F2F offer to sit alongside a telemedicine clinic, and should be for patients' to choose
- Face to Face clinics need to be as COVID-19 secure as possible, respecting Public Health England and NHS London infection prevention and control. Consideration should be given to delivering F2F clinics on non-acute (cold) sites by staff not directly involved in caring for patients with COVID-19

### What could we do better?

- Improve risk stratification, selection and consent of patients requiring F2F
- Use patient portals such as Patient Knows Best or PatientView for patient self-management
- We can improve the education we provide to patients to equip them to self-manage their condition better, and also provide the tools to be able to do this e.g. BP monitor, weighing scales, urinalysis technology
- Provide high quality education for patients and clinical teams on how to use remote consultations effectively
- Support patients to access video consultations
- Explore opportunities to work with third sector organisations to support patients to access technology through training and possibly donated hardware
- COVID-9 secure outpatient facilities allowing better physical separation of staff and patients from those caring for patients with COVID-19. Need more resilience within OPD

### What could we do better continued?

- Better access to community diagnostics whether delivered as a mobile 'pop-up' service or geographically dispersed at 'cold' sites
- Improve and standardise the collection of PAM/PROM/Frailty assessments information to enable Shared decision making, guide triaging, and also enable responsive learning and development of risk-stratification and self-management tools

## Restarting Vascular Access and Transplantation Safely

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### What worked well?

- The Independent Sector provided green COVID-19 pathways, within the national contracts, which accelerated the surgical restart programmes
- Close working between the renal networks and NHSE&I enabled good use of the Independent Sector to restart Vascular Access and Living Donor Kidney Transplant for most units in London
- The pan-London Vascular Access collaboration has empowered clinicians and has been effective to share learning and to manage the phased restart of surgery
- Living donor transplantation was restarted after patients had been surveyed and expressed a strong wish (90%) to restart
- The renal network promoted sharing of shielding and surgical protocols across units
- The concept of mutual aid is now established
- Home delivery of immuno-suppression medication was expanded in many units

### Key challenges

- Closing surgical services is relatively easy, however re-opening safely is very difficult
- Assuring equity of access has been a key challenge, particularly in the living donor cohort for complex patients and for vascular access patients already on dialysis
- Re-start plans have needed higher levels of capacity initially to reduce the backlog of activity
- Waiting time data for vascular access is not yet recorded in standard waiting lists (patient treatment list) format in many trusts
- The nature of satellite and in centre dialysis has prevented patients from meeting shielding criteria and has therefore limited their access to surgical low-risk pathways
- Guidance on isolation and shielding was not always clear, leading to issues for patients with sick pay and safety at work
- There has been a significant impact on complex patients and delays in the Deceased and living donor kidney transplant workup pathway e.g. reduced access to clean/green diagnostic facilities

### What could we do better?

- Provide more complete pan-London information on surgical capacity, demand and waiting times profiles
- Plan to accommodate high risk patients and assure equity of access for vascular access and living and deceased donor kidney transplant patients
- Develop a plan that enables some continuity of surgical procedures safely if there is a second wave of infection
- Continue to work with all units in London to standardise surgical pathways
- Follow consistent shielding guidance pan-London
- Create better measures to assure equity of access
- Review good practice across London units to share transplant follow-up process e.g. St George's ensure all transplant recipients are on home delivery from 90 days post-surgery in the absence of complications



## Appendix 2

### Slides from 01 July

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1. [Session 1 – Topic: Protecting people on In-Centre Haemodialysis](#)

Chair: Dr Jenny Cross (RFH) Patient: Maddy Warren

Patient: Maddy Warren

Panel: Dr Kieran McCafferty – Nephrologist (Barts), Helen Cronin- HD Matron (KCH), Dr Tanzina Haque/Jelena Heaphy Infection Control (RFH), Dr Simon Kirwin - Renal Psychological Medicine (RLH) and Kate Shepherd (KCH) Sarah Watson (GSST) – Supportive Care Practitioners

2. [Topic: Renal teams supporting AKI in the critically ill patient - Slidedeck 1](#)

3. [Topic: Renal teams supporting AKI in the critically ill patient - Slidedeck 2 NEL Experience](#)

Chair: Professor Claire Sharpe (KCH)

Panel: Panel: Dr Rafik Bedair & Dr Daniel Jones (STG), Dr Chris Kirwan (Barts), Dr Marlies Ostermann (GSTT), Elaine Bowes & Dr Hugh Cairns (KCH) and Dr Neill Duncan (Imperial)

4. [Topic: Remote working in Nephrology - virtual by default](#)

Chair: Dr Conor Byrne (Barts)

Panel: Dr Kin Yee Shiu (RFH), Dr Cat Shaw (KCH), Dr Edward Stern (StG), Dr Vip DeSilva (ESTH), Dr Ellie Asgari (GSST), Dr Andrew Frankel (Imperial)

5. [Topic: Restarting Vascular Access & Transplantation safely](#)

Chair: Dr Ginny Quan (ESTH)

Vascular Access: Mr Francis Calder (GSST) and Mr Rajesh Sivaprakasam (Barts)

Transplantation: Patient: Nick Palmer (KCUK)

Panel: Lisa Burnapp (NHSBT), Dr Sapna Shah (KCH), Mr Frank Dor (Imperial), Dr Gareth Jones (RFH)

## Appendix 3

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### **Conclusion and recommendations from the National Report by Smeeta Sinha and Clara Day with input from all England Regions including London [COVID-19 Response: Renal and Critical Care Engagement Lessons Learnt]**

The following recommendations are pertinent for second surge emergency preparedness as well as for longer-term renal transformation (T).

#### **4.1. Leadership**

- Formally establish Renal NHSEI regional Operational Delivery Networks (T)
- Develop regional tiered strategy to support alternative RRT on critical care unit dependent on available renal input
- Document suggested reporting models in response to future surge requirement to provide clear lines of communication, rapid decision making and avoidance of duplication
- Establish joint renal and intensive care medicine forums for engagement and regional strategies/education (T)
- Develop joint intensive care and renal training programmes for multi-professional teams (T)
- Ensure flexibility to step up responses/meetings/protocols as needed
- Ensure decisions and future policies are data driven by developing dashboards which support collection of RRT data and outcomes

#### **4.2. Protocols and policies**

- Develop and disseminate protocols, guidelines for use and training resources for alternatives to continuous venovenous haemofiltration (CVVH) as RRT within critical care units (CCU) e.g. slow low efficiency dialysis (SLED), IHD
- Ensure step down criteria in place from critical care to wards
- Ensure AKI guidelines and pathways in place at each trust to reduce AKI incidence prior to need for RRT e.g. AKI champions/leads
- Ensure patients receive right care at the right place by supporting direct conveyance via ambulance services
- Encourage involvement of renal teams in CCU admission and RRT initiation decisions

#### **4.3. Staff**

- Acknowledge regional and provider variation in requirement to support:
- Training of CCU staff to deliver alternative RRT
- Development of outreach alternative RRT teams (PD/HD) including medical and nursing models
- Acknowledge renal teams will be supporting regional CCUs as well as hub centres
- Ensure renal consultant-led support available to all critical care units (T)

- Ensure dialysis trained staff are prioritised for delivery of RRT rather than redeployment
- Ensure renal medical staff are prioritised for delivery of RRT rather than redeployment
- Encourage joint appointments: intensive care medicine and renal consultant (T)
- Encourage joint ICM and renal training opportunities (T)
- Encourage development of AKI teams to improve AKI care throughout hospital: AKI nurses/medical in-reach (T)
- Ensure renal nurses are recompensed at the same rate as CCU nurses for any work undertaken as part of a national emergency response
- Ensure administrative support available to support critical care/renal activity/data collection

#### 4.4. Resources/infrastructure

- Acknowledge renal services are unable to support alternative RRT on all CCUs. Support a regionally agreed 3-tiered approach to critical care accreditation for renal replacement therapy:

Tier 1) Ring-main water supply with daily alternative RRT co-located with renal centre

Tier 2) Alternative RRT available but not co-located with renal centre

Tier 3) No alternative RRT but prioritised for CVVH consumables

- Ensure clear commissioning pathways for delivery of RRT on critical care without negatively impacting on delivery of maintenance programmes
- Ensure clear commissioning pathways to facilitate changes in capital investment required to provide 3-tiered approach
- Ensure adequate local and national stockpiles of key consumables and equipment in place
- Explore feasibility of UK based CVVH fluid development
- Support digitally enabled review services including electronic prescriptions to support remote working and infection prevention and control measures