NHS
Birmingham Community Healthcare
NHS Foundation Trust

Chronic Kidney Disease (CKD) Service

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Healthy Communities

Open
Responsible
Caring
Respectful
Inclusive

Contact Details:

- Chronic Kidney Disease Service (CKD) St Stephens Centre,171 Nineveh Road, Handsworth Birmingham B21 0SY
- Tel. no. 01214663680 – Office hours 09:00am to 17:00pm Monday to Friday excluding bank holidays and weekends.
- Email: bchnt.ckdreferrals@nhs.net

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How to access CKD community service?

- Referrals are accepted from GP's and multi-disciplinary teams e.g., Diabetes Team, Heart Failure Team, District Nurses, and other adult services.
- Referral forms can be downloaded from the Birmingham Community Healthcare NHS Foundation Trust website:

https://www.bhamcommunity.nhs.uk/patients-public/adults/chronic-kidney-disease/

Or sent via Fax2Mail :0116 227 3073 or email via bchnt.ckdreferrals@nhs.net

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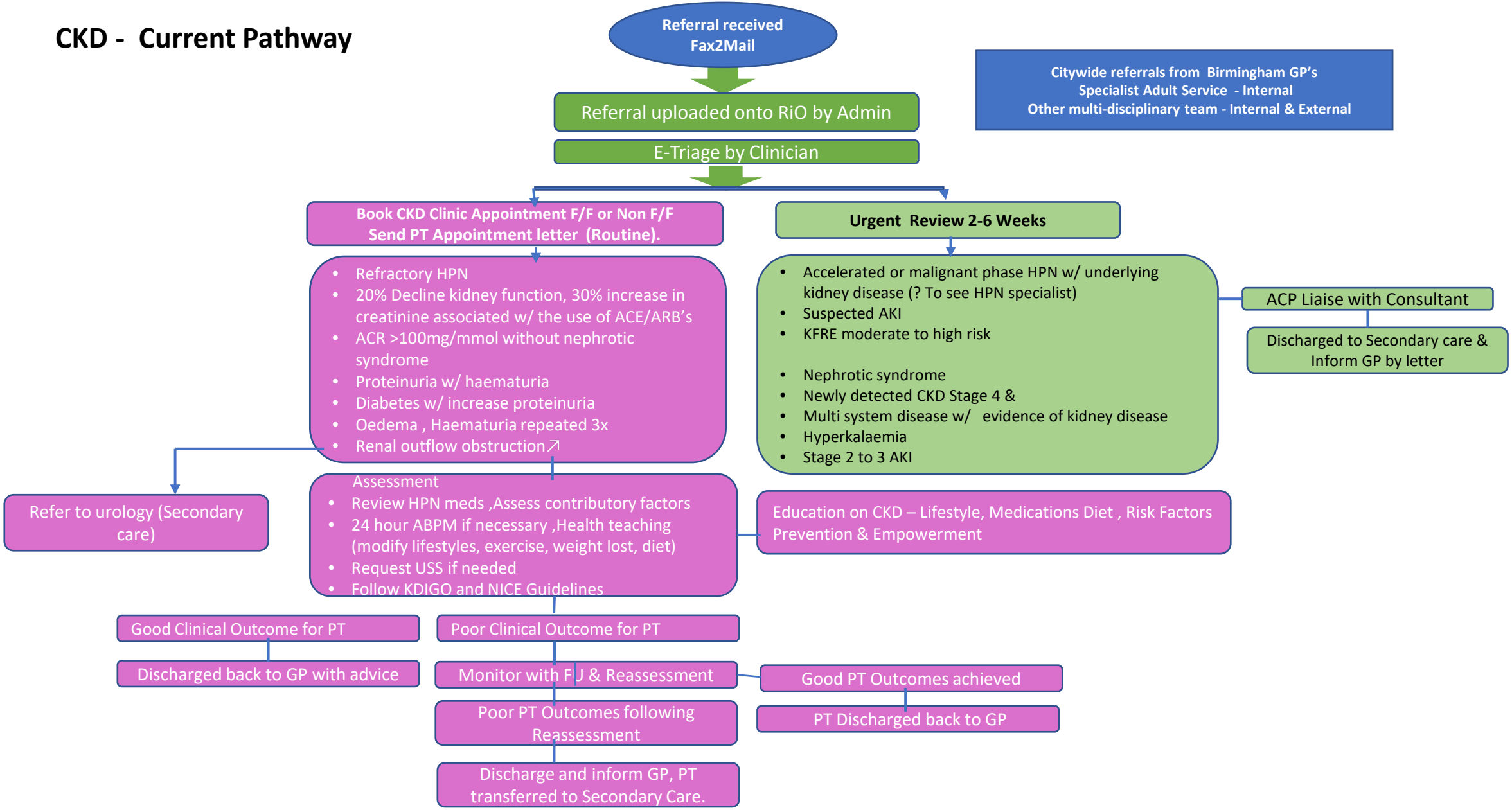
What do we do?

- Raise awareness of Chronic Kidney Disease (CKD) and the health effects that may happen if you have this condition.
- Assist GPs (primary care teams) to investigate if patients have CKD and support them caring for high-risk groups (e.g., people with pre-existing diabetes, cardiovascular disease (CVD).
- Provide advice and guidance to primary care so they can support patients with lower CVD risk and reduce the speed their CKD develops.
- Work with patients to create a plan to help them manage their CKD. Suggest useful resources that can support their education; ensuring their care needs are balanced with any risks.
- Provide local community clinic reviews by a Kidney Specialised Consultant and an Advanced Clinical Practitioner for patients with CKD.
- Educate CKD patients and their families on how best to support self-management of their condition.
- Work closely with secondary care services such as kidney disease, heart failure and diabetes so the transfer of CKD patients care is transitioned smoothly between services.
- Where dialysis is not appropriate, we provide support for individuals and other healthcare staff in delivering high quality end of life care.

CKD - Current Pathway



Next Steps

- **Patient centred-care.**
- **New pathway/model.**
- The Pathway to include collaboration with other services dealing **Long-term Conditions** (Heart Failure, Diabetes, Respiratory, Frailty). This maybe through internal referrals, MDT, education on awareness and early identification of CKD/AKI
- Incorporate **Integrated Care System**
- **Support Education for CKD patients and family** – enable patients to actively participate in their care (self-care and self-management) according to NICE guidelines i.e. consider patient's preferences, provide information, provide clinic letters, Patient Initiated Follow up (PIFU).
- Service CKD leaflet and engagement with GP's. – leaflet is already available in CKD BCHC web page.
- **Shared Decision making (MDT).**
- Education and training to health practitioners – to include on awareness of AKI
- **Virtual platforms/virtual clinics** – Attend anywhere is already is running. Consider virtual advice from nephrologists for complex patients.
- AKI post discharges – RIO alert to follow up patient.

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Thank you for listening