

# Topic: Remote working in Nephrology - virtual by default

**Chair: Dr Conor Byrne**

**Purpose of the session:**

- To share learning from the rapid expansion of remote working during the COVID surge and understand how recent experience has influenced future thinking.
- To set a path for innovation and fundamental change in working practices to enable a sustainable reduction in face-to-face clinical practice across all kidney care pathways.
  
- Dr Andrew Frankel (Imperial)
- Dr Cat Shaw (KCH)
- Dr Kin Yee Shiu (RFH)
  
- **Panel:**
- Dr Edward Stern (StG)
- Dr Vip DeSilva (ESTH)
- Dr Ellie Asgari (GSST)



# Dr Conor Byrne

## Consultant Nephrologist

Barts Health NHS Trust



# Dr Andrew Frankel

Consultant Nephrologist

Imperial College Hammersmith Hospital

# Covid 19 and Outpatient Services

How did we respond  
What were the challenges

# Reflex

- Outpatient services were generally scaled back
  - Patients triaged
    - Appointments postponed (not everywhere)
    - Some patients discharged
    - Some patients needed a review – undertaken in a variety of ways

# Remote options

- Remote Virtual - where the patient is reviewed in their absence and clinical advice given
- Remote Telephone – Consultation occurs with the patient via telephone
- Remote Video – Consultation occurs with the patient via video
  - Attend anywhere -

# Already in Place

- Telephone consultations being considered in a few centres with little actual activity
- Barts model – Fully rolled out in NE London and also blood only clinic
  - Virtual Service - Fully rolled out in NWL (final CCGs added)
  - Partial rollout Kings
  - Provided ability to continue to receive new patient referrals but numbers down as Primary Care were not seeing as many patients

# Challenges and solutions – Patient Perspective

- Challenges
  - Letting them know what is happening with their appointments
  - Determinants of successful remote consultation
    - Advocates and communicating
    - Self care dependent
- Positives
  - Encouraged self care
  - Imperial PIS remote clinics and BP monitoring
  - Patient access to advice – Barts email inboxes



# Challenges and Solutions - Technique

- Challenges
  - New ways of working
  - Missing potential physical and psychological nuances of the consultation
  - Trainees involvement
- Positives
  - Guides to the remote consultation
  - Attend Anywhere – once running and trained - worked
  - Less DNAs

# Challenges and solutions - Phlebotomy

- Challenges
  - Patients concerned about coming up for bloods
  - Access to community phlebotomy patchy and issues around transfer of results if systems different – needs integration
- Positives
  - Kings Mobile Van
  - GSTT setting up phlebotomy outside hospital

# Challenges and Solutions - Technical

- Technical
  - Establishing Video – Hardware in place
  - Patients currently easy to contact ?will this change post lockdown
- Clinician time
  - Screening lists
  - ?longer time required
- Administrative support
  - Moving patients, informing patients, changing slots - video

# Key Messages

- Huge amount of work
- Enabled innovation (rapidly)
- Enabled new ways of working (rapidly)
- Consideration of the purpose of the OP consultation

## **Panel Discussion**

**Dr Andrew Frankel ( Imperial)**

**Dr Cat Shaw (KCH)**

**Dr Kin Yee Shiu (RFH)**

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**Dr Ellie Asgari (GSST)**



# **Dr Cat Shaw**

## **Consultant Nephrologist**

Kings College Hospital

## Creating a sustainable and innovative kidney care future: remote consultations

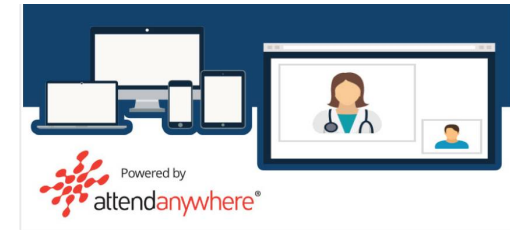
Dr Catriona Shaw



## Creating sustainability

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1. Portfolio of services- F2F, video, telephone, virtual
2. Simple referral pathway for primary care; Robust pathways /IT solutions for rapid response back to GP re A+G (E advice) and clinic Ix/results
3. Robust administration/IT pathways- triage, bookings, outcomes
4. Effective linkage between IT systems
5. Community phlebotomy solutions
6. Roll out of VC service
7. Clinic space/infrastructure, equipment (patient/clinician)
8. Patient co-design/ information and education
9. Support from commissioners/primary care and fellow NHS trusts





# Opportunities for innovation

Agile,  
responsive

Less impactful  
for  
patients/carers

Reducing  
hospital visits

Integrated  
care:  
long term  
conditions

Robust,  
connected  
services

Co-  
directed  
care



Research/  
QI

MDT sub  
specialty  
clinics

Public Health  
England

### Whole system approach

Sustained changes to individual behaviours across the whole population will require:

- Multiple actions across all parts of the **system**
- Changes to the food, physical activity and social environments

Linked  
records/IT

BIG DATA

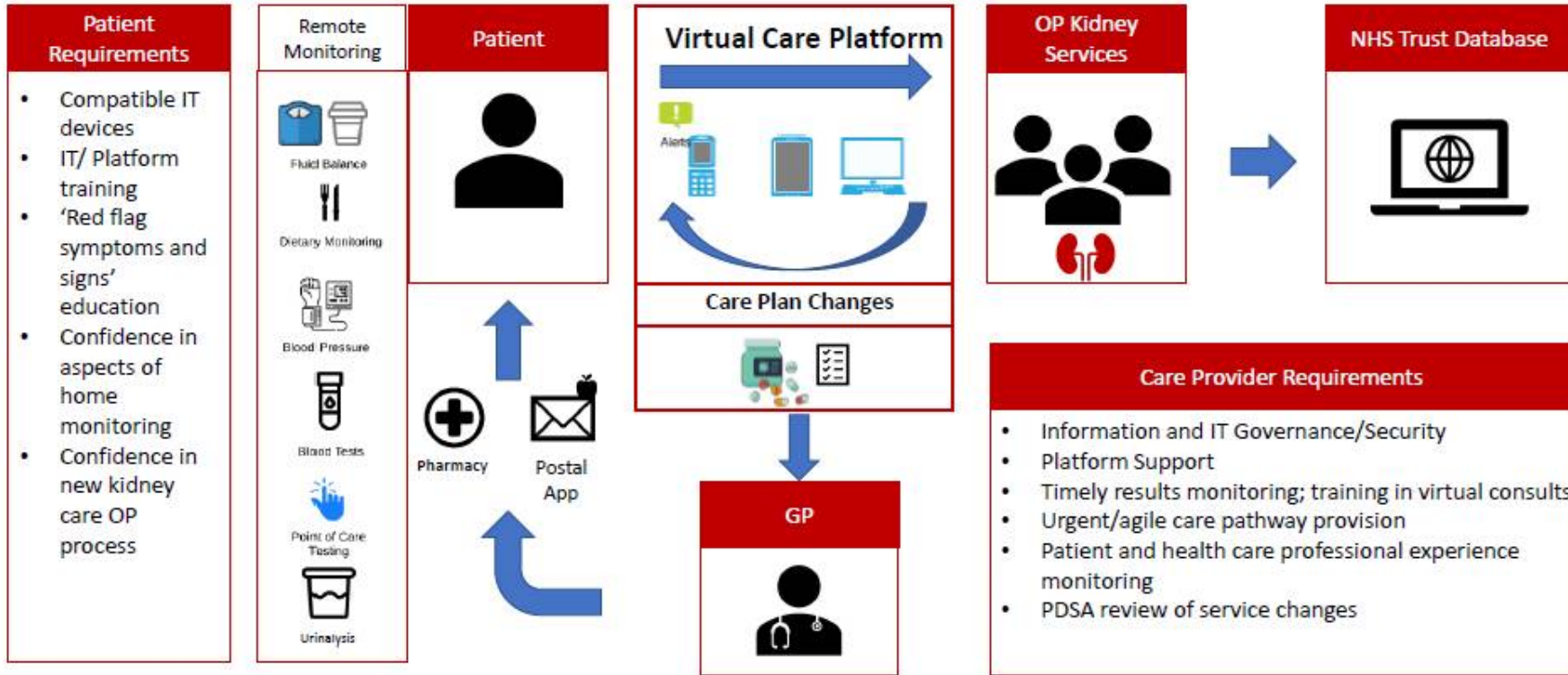


# Outpatient Kidney Services 2020: Overview



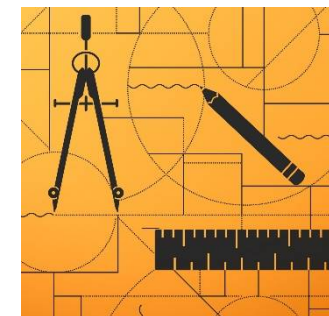
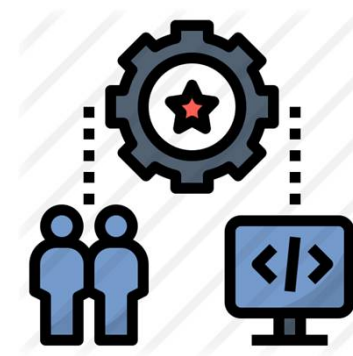
## UK Outpatient Kidney Services 2020: Overview

**Aim:** To provide technology supported, flexible, high quality outpatient care options for kidney patients





A NEW WAY  
OF THINKING



## **Panel Discussion**

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# **Dr Kin Yee Shiu**

**Consultant Nephrologist/Acute  
Medicine**

Royal Free London NHS Foundation Trust

## NCL Renal Network

### Aims

#### Renal Outpatients Aims/ Goals

- Increase patient self-care and self-management
- Specialist renal services providing world-class expertise and local care
- Protecting patients (infection prevention and control)
- Equal access, increasing standards of care for all
- Sustainability and the environment

Defer / Reduce frequency of visits

Video appointment

Telephone appointment

Face to face appointment

### Categorisation / Group

Stable patients (e.g. stable CKD managed in 1ry care but also long-term transplant, stable nephrotics etc)

Suitable for local (community) monitoring (no need for specialist Ix, or already under another specialist team so can have MDT care)

Self-monitoring and patient-initiated follow-up

Long-term patients who do not need clinical exam but do require regular monitoring e.g. transplant follow-up, nephrotics, young adults

Risk of attending does not warrant visit, but can be done v. well remotely (Psychology, dietician)

Tertiary services for new patients to RFH (e.g. Metabolic Stone, Complex Hypertension with process for pre-clinic tests etc)

Rapid post-admission follow-up / review

Stable patients who do not want/ cannot have video consultation (capability / equipment)

Risks of attending clinic greater than need to be clinically examined

Vulnerable (domestic circumstances)

Frailty, dementia, interpreter, disability (e.g. hearing), difficult conversation (bad news)

Examination e.g. skin, clinic BP, fluid status

Risk of not seeing (e.g. admission) greater than infection risk

### How / What is required

Patient awareness and engagement

Easy access to clinician by pt / GP

Easy appointment rescheduling (remote if suitable)

GP Advice and Guidance / EMIS / RAS

Shared information (HIE, other hospital letters/results)

Patient to have access to equipment

Privacy / dignity needs to be preserved

Patient engagement / engaged to have investigations e.g. BP etc pre-clinic

Hospital-prescribed drugs to be home-delivered (or can be collected)

Adequate staff equipment/space (webcam, microphone, booths?)

Clear troubleshooting guide/contact by phone if video connection drops

Clear plan of what to do if patient appears unwell

Excellent "triage" / escalation e.g. by GP / patient / carer / social care / ED

COVID protected / Risk Managed pathway

Shielded / vulnerable patients seen first? Clinic location – e.g. satellite

# Qualitative staff feedback

## Video working well

Patients appreciate remote consultation

Promotes self-management – home BP, ordering medication, arranging blood tests

Promotes patient's family engagement

Can be used to teach/prompt patients e.g. how to do BP correctly, peritoneal dialysis techniques

Pre-clinic prep and ensuring blood results available for the video consultation increases effectiveness of consultation and reduces MDT tasks post-clinic (as decisions made in clinic)

Reduced waiting time between patients / clinic delays

Positive environmental impact due to less travel required (local blood tests where possible / needed)

## Problems encountered

Patient identification in waiting rooms difficult as it gets busier

Phone notification (of patient checking in) does not discriminate between clinicians

Pre-clinic prep needed by patient e.g. getting BP done, having medication list on hand

Accidentally joining another person's consultation – needs a "locking" facility

Many renal patients require blood tests (doing these in advance requires more admin time/ support)

Internet connection drops / is not strong enough

Attend Anywhere unreliable – recurrent downtime

If connection drops, re-connection slow, and display shows "being seen" when not the case

15 minute appointment slots minimum needed

# Transplant Consultant and Nurse Feedback

## Ease of use

9.7 / 10

## Perceived patient benefits

- Less time off work / arranging child care All
- Reduced financial burden All
- More convenient/comfortable, reduced waiting room crowding All
- Increased patient engagement 50:50 (can engage freq. DNA)

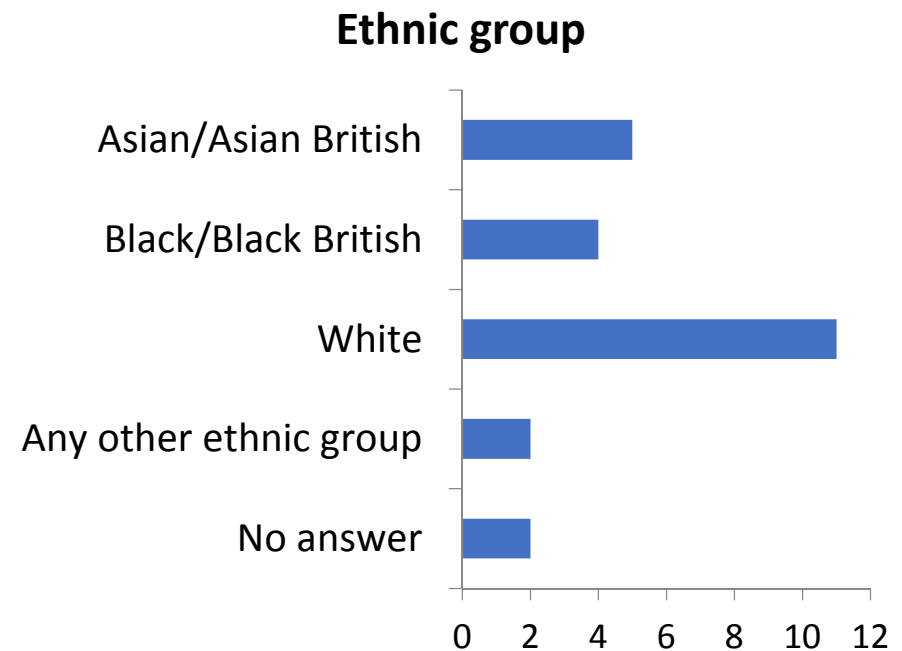
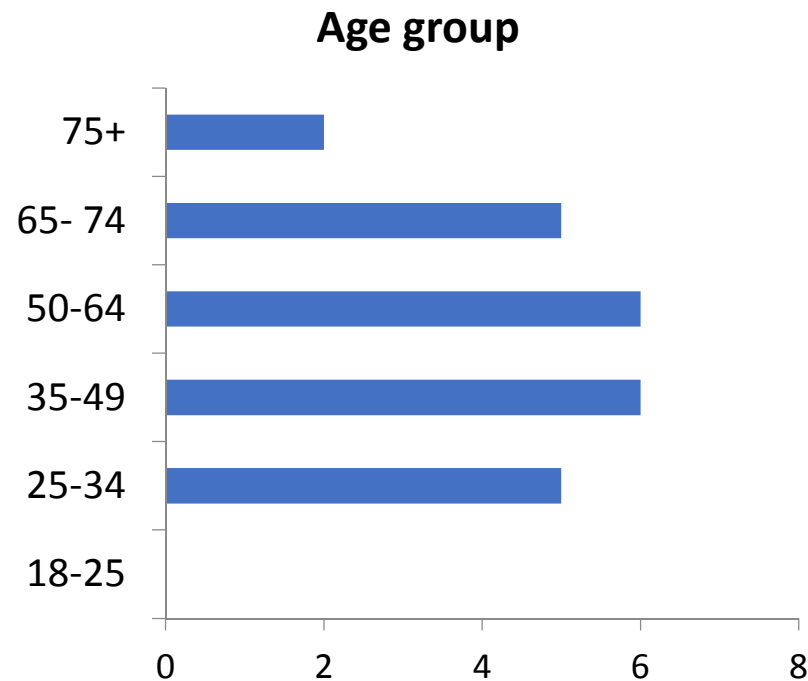
## Staff experience

- Able to communicate well in all cases All
- Offers ability to review patients safely All
- Not more stressful, don't mind not seeing patients face to face All
- How would you rate your experience compared to face to face? 1/3 worse, 1/3 better, 1/3 same
- All wanted to continue to use video clinics with 75:25 virtual to face-to-face split recommended



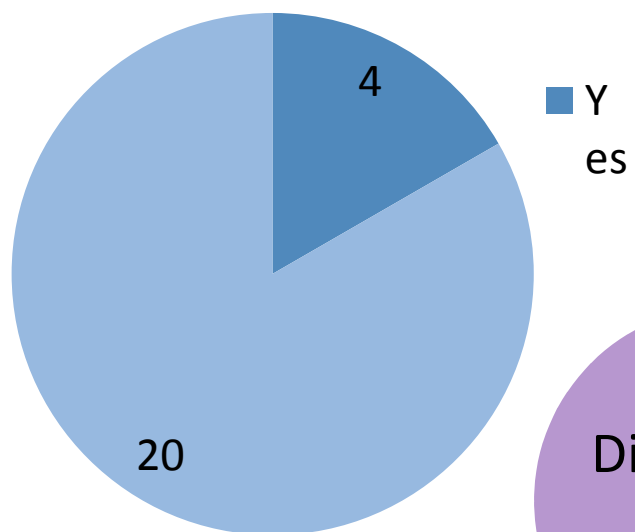
# Patient Attend Anywhere feedback

- 24 patients who had a Renal or Renal Transplant video consultation were asked for their feedback at the end of their consultation using the standard Trust / Attend Anywhere survey.

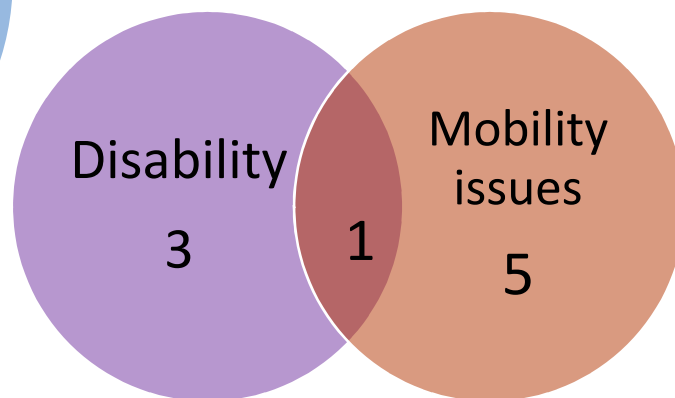
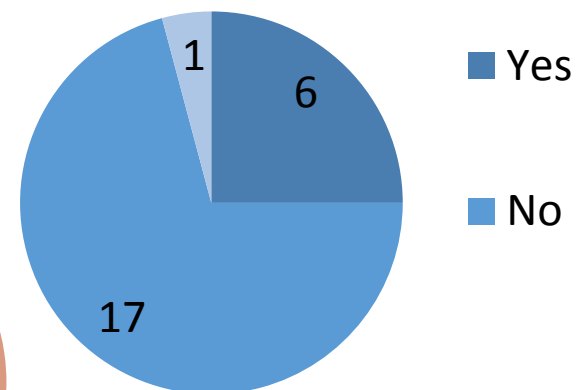


Almost 40% of patients expressed they either have a disability or issues with mobility

Do you have a disability?

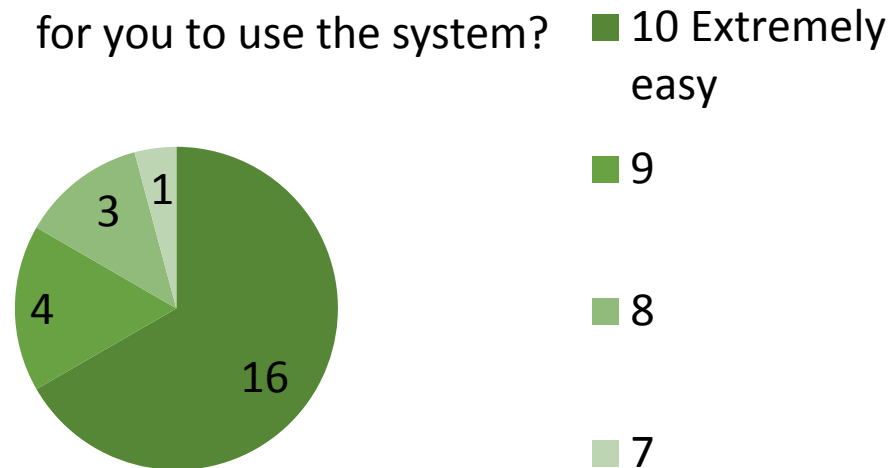


Do you have any difficulties with mobility?



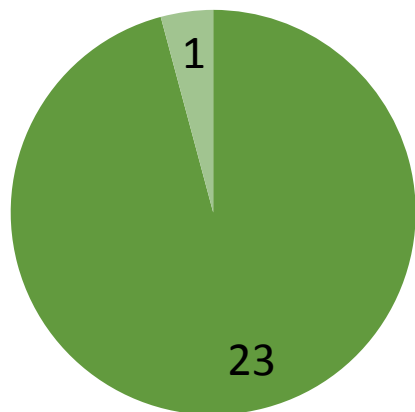
# Majority found it easy to use, despite it being new to them

Using any number from 1 to 10, where 10 is extremely easy and 1 is extremely difficult, what number would you use to rate how easy it was for you to use the system?

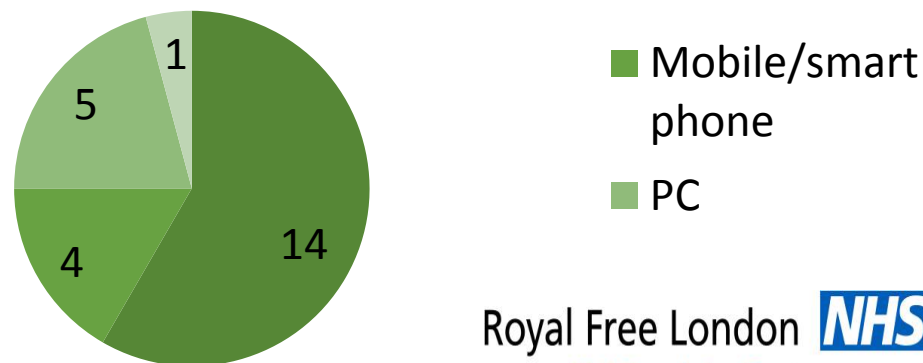


Was this your first time using a video appointment?

■ Yes ■ No

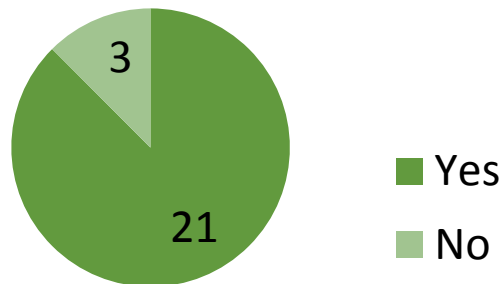


Please can you tell us what device you used to have your video appointment?



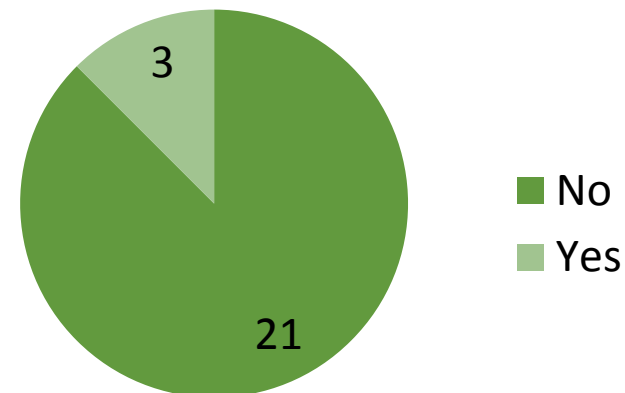
# 88% of patients were able to access without assistance

Were able to access your video appointment yourself or did you need help?



3 patients needed help – all from family

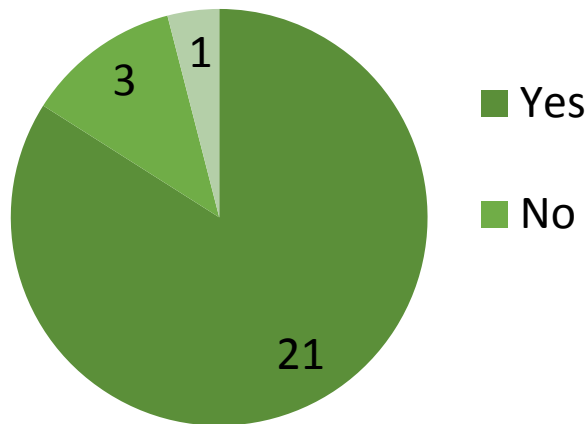
Did you experience any technical difficulties?



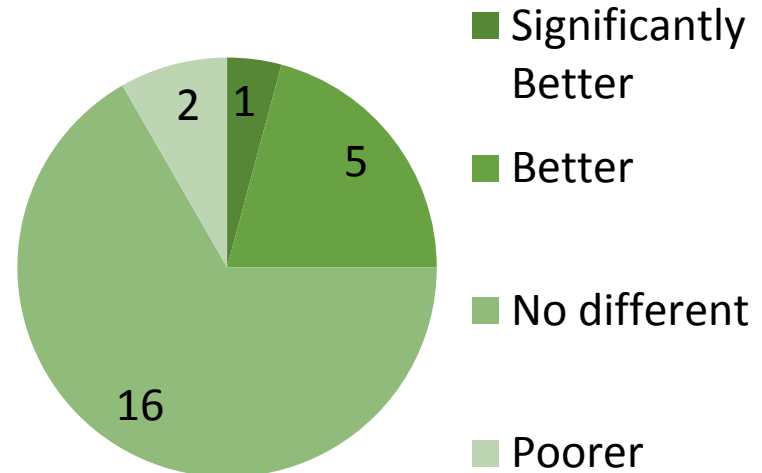
- 1 Problems with audio/sound quality
- 0 Problems with video/picture quality
- 2 Problems with internet connection
- 1 Problems with the browser
- 2 Other (please specify)  
problem with copying the link sent, that popped up on the screen  
Had to download Chrome to use it. Firefox is our normal browser

88% felt they communicated all they wanted with clinician &  
92% felt this was better or no different to face to face

Did you feel you were able to communicate everything you wanted to your healthcare professional during your video appointment?



How would you rate your experience of your video appointment compared with your previous face-to-face appointment(s)?



# Looking to the Future

## **Group consultations using remote technology**

- Group video consultations e.g. for CKD, transplant, live donor / transplant education, pre-dialysis options for both education and individualised care, engaging family and carers whilst reducing travel / risk of infection
- Multi-professional video consultations e.g. consent clinic with clinician, pharmacist, specialist nurse

## **Integrated care**

- Support GP group consultations e.g. in CKD
- Co-ordinated long-term condition care e.g. community heart failure and CKD, diabetes and CKD to reduce patient visits to hospital and increase standard of care
- Work with ICS to develop links with frailty hubs, social prescribers, third sector etc to improve patient outcomes and ensure equality of access

## **Reducing patient visits to hospital whilst improving care / training / standards**

- Combined clinic visit where face to face essential e.g. transplant dermatology, together with annual review for transplant follow-up; diabetic foot clinic with dialysis visit; vascular access with transplant assessment

## **Patient experience**

- Patient participation and feedback to develop service
- Peer network development through group consultations and develop peer to peer support with telephone/video

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**Moderator: Dr Ravindra Rajakariar - Barts Health**

# Summing up of key messages

Dr Conor Byrne