Newham Protected Learning Time Agenda

Thursday 6th July 2023, 14:30 – 17:30

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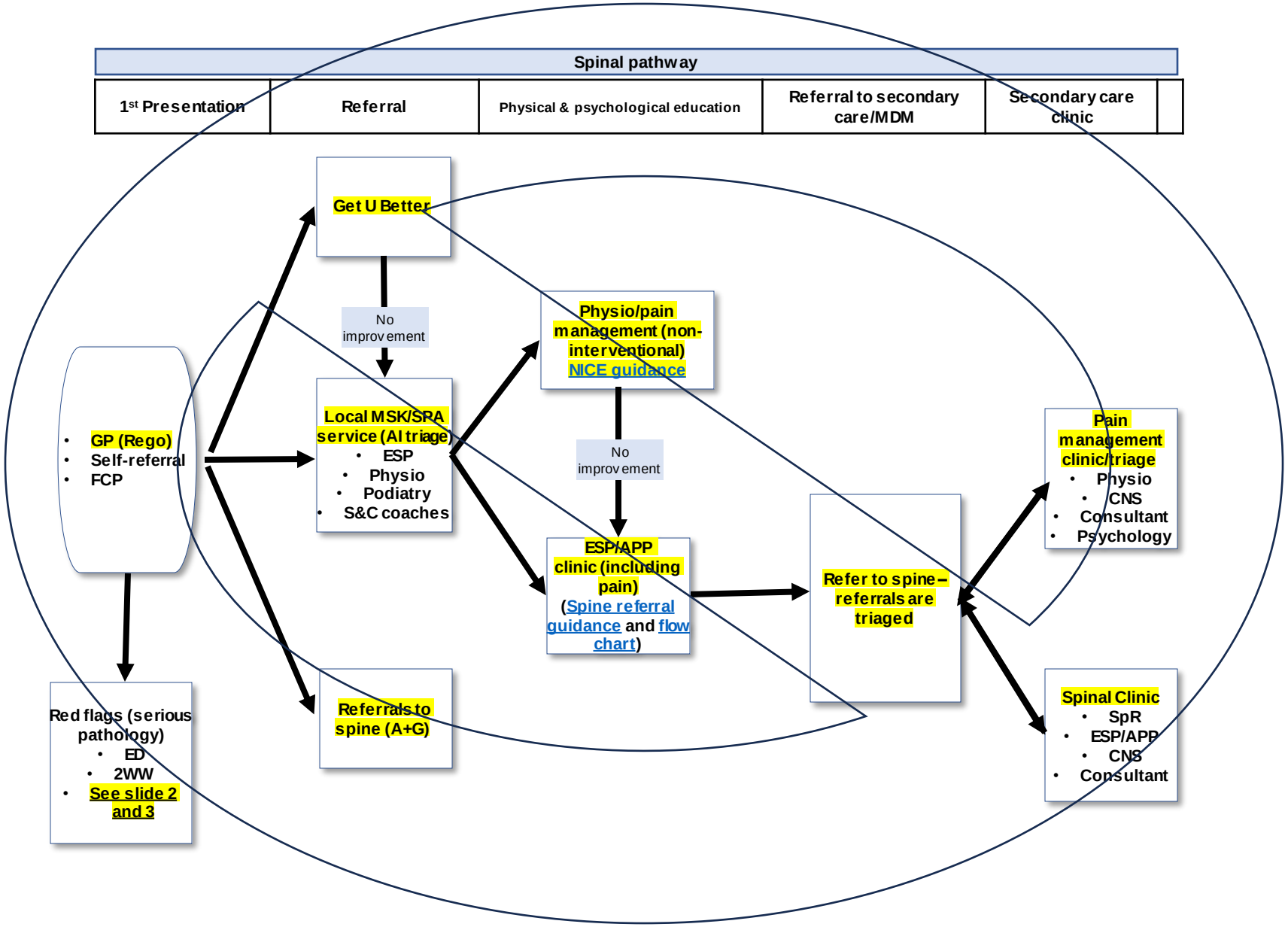
	Agenda Items	Lead	Times
1	Spinal Pathways • *Referral pathway to spine* • *What to refer to the spine service* • *Cauda Equina and MSCC pathway*	**Phil Barber** - Advanced Physiotherapy Practitioner & Clinical Pathways Lead (NE London and Essex Spinal Network)	14:30 – 15:00
2	MSK Self-Management App	**getUbetter**	15:00 – 15:15
3	Break		15:15 – 15:20
4	Cancer • *Update on new urgent suspected cancer referral forms* • *PSA reference changes and Colon Flag* • *Early Diagnosis DES: learning so far and next steps* • *Non-site specific cancer pathway* • *CEG resources* • *Quality issues and service alerts*	**Dr Helen Stedeford** - Newham Clinical Lead Cancer	15:20 – 16:20
5	Break		16:20 – 16:30
6	CKD • *Management of CKD - "3 within 3"* • *New therapies for CKD* • *Useful resources for CKD management*	**Ademola Olaitan -** vCKD Newham	16:30 – 17:30

Old pathway – still in use in some parts of NE London

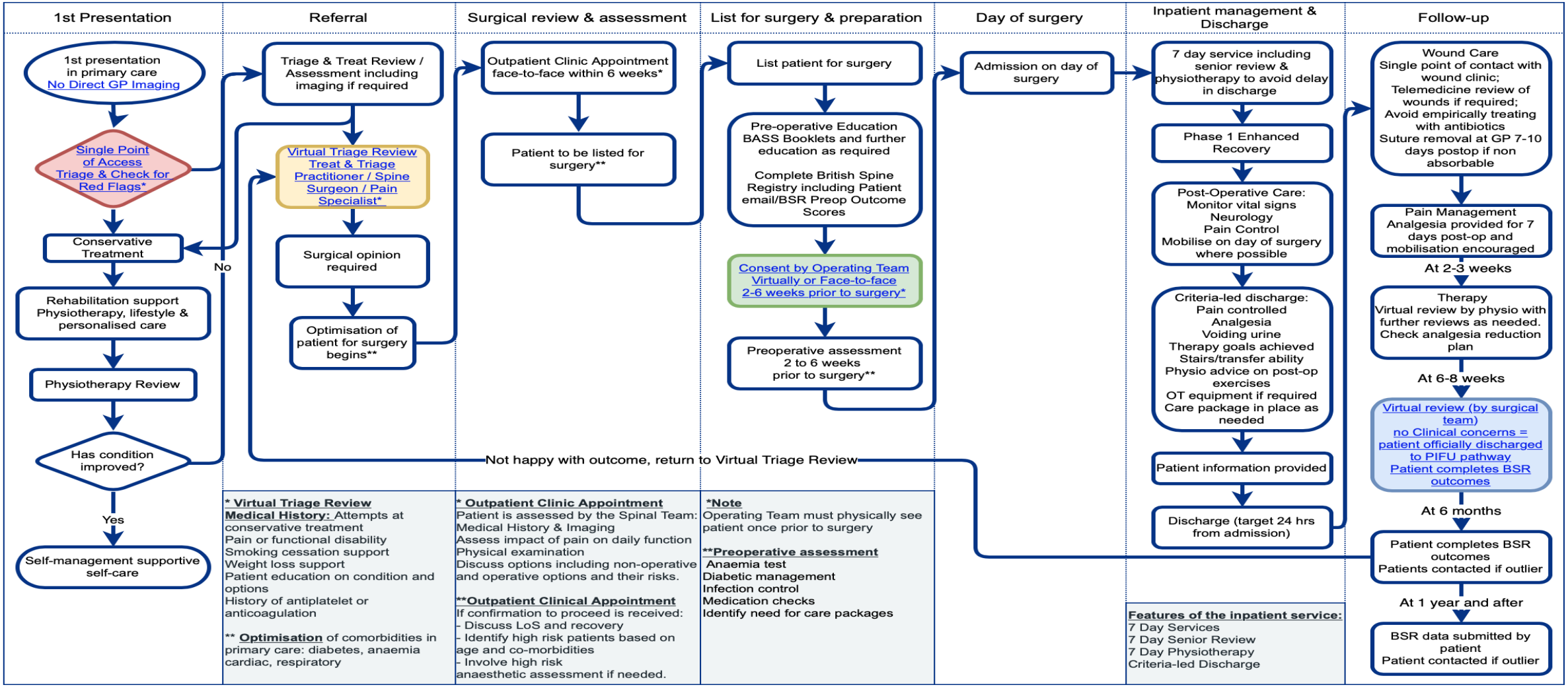


GIRFT pathway – current pathway in Newham

GIRFT – Getting It Right First Time | Faculty of Pain Medicine of the Royal College of Anaesthetists | National Spine Network | BASS – British Association of Spine Surgeons | British Association of Day Surgery | The British Pain Society | Society of British Neurological Surgeons | UKSSB

Back and Radicular Pain: Posterior Lumbar Decompression / Discectomy - Version 15.0

Spinal Surgery



Referrals

TAKE A PICTURE OF THIS ON YOUR PHONE/LAPTOP AND REFER BACK TO IT

Referrals to spine are via MSK service – please contact MSK team if concerned about a patient and you feel they need a spinal review urgently

- No red flags AND the patient has not had physio and they have a normal neurological examination – refer to MSK/physiotherapy

Do not request an MRI/x-ray at this stage

- If the patient has myotomal weakness or loss of hand dexterity on examination then will require an MRI scan

The patient should be referred to spine only if the MRI scan correlates (e.g. L5 myotome weakness and L5 nerve impingement/compression) - via MSK service

Vertebral fragility fractures: refer to spine if ongoing pain **AND** MRI reports bone marrow oedema at fracture level

Scoliosis: can be referred without x-ray if noticeable curve.

Click here to return to contents page

Spinal injections

TAKE A PICTURE OF THIS ON YOUR PHONE/LAPTOP AND REFER BACK TO IT

Refer to pain management for the following (**spine service at NUH does not offer therapeutic, standalone injections**):

Medial branch block injections

- Only if physio and non-invasive pain management has not helped

AND:

The pain is more back pain and not nerve like in the legs

Epidural

- Consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica.

- Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

Click here to return to contents page

Triaging to spine guidance

Recommended minimum information on your referral to MSK:

1. Pain referral location – back, back and leg (dermatome)
2. Neurological examination findings
3. Previous treatment

- Red flag patients should not be referred to spine on eRS/routine referral methods (e.g. CES, infection, MSCC – refer to appropriate pathway)

*Scoliosis patients can be referred on without any imaging

National Suspected Cauda Equina Syndrome Pathway

Spinal Services

Primary & Community Care Presentation

Presentation in Primary & Community Care

Triage assessment of patient and symptoms*

Sudden onset bilateral radicular pain or unilateral radicular leg pain that has progressed to bilateral without CES symptoms
or
Onset of CES symptoms >2weeks

Patient has recent (<2weeks) onset of CES symptoms

Urgent referral to MSK triage service**

Refer as an Emergency to nearest hospital with Emergency MRI provision***

<2 weeks

Deteriorating / New CES symptoms since referral

Triage patient with CES symptoms

Static / No new CES symptoms

Follow pathway for Posterior Lumbar Decompression/ Discectomy (link)
Acquisition / urgency of MRI is at clinician's discretion

*Emergency referral after a telephone assessment identifying CES symptoms is acceptable if immediate face to face review is not possible or will delay referral.

**to be seen within 2 weeks, highlight referral as Urgent/Bilateral Radicular Pain and document signs, symptoms, frequency, duration and progression. Time and date of assessment(s). Subjective perianal sensation should be recorded. Document no CES

Hospital Presentation & Diagnosis

Presentation in secondary care*

Triage assessment of patient and symptoms

atient has recent (<2 weeks) onset of CES symptoms

Perform bladder scan

Emergency MRI as soon as possible, and certainly within 4hrs of request

Outcome of Imaging reviewed

No cauda equina compression but neural compression to explain radicular pain (sciatica)

Cauda Equina compression confirmed

No cause for symptoms found

*consider Same Day Emergency Care model run outside the ED

Further reading and resources:
Aspire (benefits advice)
BASS CES booklet
Cauda equina champions charity
Multidisciplinary Association of Spinal Cord Injured Professionals
NCEPOD Classification of intervention
NICE NG180
NICE NG59

Surgery

Keep patient nil by mouth
Immediate emergency referral to spinal surgical service

If transfer required, arrange blue-light Category 2 ambulance transfer

Assessment and documentation by surgical team

Consent

Register patient on British Spine Registry

Catheterisation prior to surgery (if not catheterised)

Surgery performed as an emergency. CES sits between NCEPOD levels 1 and 2. It is time-sensitive and life-changing, but not life-threatening

Post-Operative Care

TWOC post-operatively (as soon as possible) and obtain pre/post void bladder scan

Patient mobilised (usually day 1) following surgery
Information booklet provided during inpatient stay.
Surgical, medical and physiotherapy assessments made.
Splints/orthotics fitted if required.

Assess requirements for ongoing support with pain, psychology, sexual health, bladder & bowel health

6/8 week post-surgical face-to-face outpatient review

Re-assess requirements for ongoing support with pain, psychology, sexual health, bladder & bowel health

Are ongoing symptoms present?

No

Yes

PIFU for 6 months

Refer to Spinal Cord Injury Team +/- Urology Team

Signpost to patient support groups

Consider alternative diagnoses
Consider referral to other specialties

MSCC Referral guidance

Patient cue card:
https://www.christie.nhs.uk/media/1125/legacymedia-1201-mscc-service_education_mscc-resources_red-flag-card.pdf

Diagnosing & Managing Metastatic Spinal Cord Compression

1. Full neurological exam with documented sensory level
2. Nurse patient flat with neutral spine alignment, log roll
3. Inform MSCC co-ordinator urgently for advice:

- **Royal London/Whipps/Newham**: call **07957 724 979** in working hours or OOH call 02073777000 and ask for on-call Oncology Registrar
- **Queens Hospital**: call 01708 435 000 ext: 6408 (9-5 pm). OOH: bleep neuro-surgical registrar on 6177
- **Southend/Basildon**: MSCC Coordinator Oncology SpR bleep: 4001 via switchboard. OOH: via switchboard ask for on-call reg for oncology.

4. **If neurological deficit on examination refer patient to local A&E immediately for whole spine MRI and MUST BE within 24 hours of presentation with any red flag symptom of MSCC -** (if MRI contraindicated consider CT).
5. If normal neurology: arrange urgent MRI scan within 7 days (two week pathway or discuss with oncology)

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Newham
Cancer Clinical Update

What's NEW and what do YOU need to do – 6th July 2023

Order of the day

Dr Helen Stedeford GP Lead for Newham

	Subject	Presenter	Rough Timings
1.	Introduction and Brain Teaser	Helen Stedeford	3.20pm
2.	USC forms	Helen Stedeford	3.25pm
3.	PCN DES – recap of requirements, learning so far	Helen Stedeford and Jessica Lewsey	3.30pm
4.	MDRAC overview	Chris Sivell	3.45pm
5.	CEG Resources	Karishma Bhuruth	3.50pm
6.	Quality and Service Alerts overview	Katherine Mutsvanga	3.55pm
7.	NEL Cancer Alliance	Saira Parker-Deeks	4.05pm
8.	Quality Cancer Care Reviews, life with/beyond cancer	Helen Stedeford	4.10pm
9.	Reflections, final Q&A	Helen Stedeford	4.15pm

Urgent Suspected Cancer Forms (old name 2WW)

- Generic changes for all forms on 31 January 2023 – redesigned. On CEG RP.
- Bespoke clinical referral guidance for each tumour site with clearer directions to alternative management and referral options if patient does not meet the defined USC referral criteria.
- Updated patient information leaflets which will be available in many community languages and easy read versions.

Urgent Suspected Cancer Form Changes (old name 2WW)

Tumour site	Changes to referral criteria	Comments on changes to form
Brain	No	-
Breast	No	Revised categorisation of gender categories by referral criteria
Children's	No	Greater emphasis on need to discuss any potential referral with on-call paediatrician
Gynaecology	Yes	More detailed definition of the criteria for: • Suspicious post-menopausal bleeding if patient is on HRT • Abnormality on **cervical, vaginal and vulval** examination suspicious of malignancy
Haem Oncology	Yes	More detailed definition of criteria for: • Thresholds for laboratory abnormalities suspicious of **myeloma** Clinical features of suspicious **lymphadenopathy**

Endometrial Cancer

- Offer **Direct Access Pelvic Ultrasound** for patients aged 45 and over with unexplained symptoms of vaginal discharge who:
  - Are presenting with these symptoms for the first time
  - Have thrombocytosis
  - Report haematuria**

***** Please note:*** Some patients may report vaginal bleeding as haematuria – please also consider urological causes

Endometrial cancer

- Abnormal abdominal/pelvic ultrasound suggestive of endometrial cancer
- Post-menopausal bleeding (more than 12 months after menstruation has stopped because of the menopause)
- Unscheduled bleeding for 4- 6 months after starting HRT (it is normal to bleed for the first 4 months after starting HRT or changing HRT preparation; any unscheduled bleeding thereafter should be investigated)
- Suspicious symptoms or signs (see boxes above) but no GP direct access imaging

Head and Neck	Yes	• Creation of separate Medical (all H&N cancer sites) and Dental (Oral/Lip only) forms • Reduction in number of criteria for referral by merging and tighter wording for **laryngeal, pharyngeal, ear, sinus and nose** cancers • More detailed definition of criteria for: - Suspicious **neck mass** and / or **thyroid lump** - Suspicious findings on **oral / lip** examination
Lower GI	No	Criteria in line with recent BSG guidelines on use of FIT for symptomatic patients – these were changed in 2020 during the Covid pandemic
Lung and Pleural	No	• More detail on appropriate situations to refer if NG12 defined high risk criteria not met including where Chest X-ray is normal Additional criteria for referral if unexplained cough and weight loss
Ophthalmology	Yes	• Re-categorisation of existing clinical criteria along more anatomical lines • Clearer definition of ocular abnormalities that warrant suspicion

Sarcoma	No	• No changes to clinical criteria for referral • Greater direction to arrange ultrasound / CT scan of lump before referral
Skin	No	• No changes to clinical criteria for referral • Greater direction to use of teledermatology services where criteria not met
Upper GI	Yes	Reduction in age threshold for referral for **all upper GI cancers**, if weight loss and suspicious symptom/s from ≥55 to ≥50 years
Urology	No	Incorporation of new recommended PSA thresholds for prostate cancer referral

Please access their educational support guides & new patient leaflets

https://www.transformationpartnersinhealthandcare.nhs.uk/our-work/cancer/early-diagnosis/two-week-wait-referral-repository/suspected-cancer-referrals/

Pan-London Suspected Urological Cancer Referral Guide

Prostate: Criteria for offering diagnostics

- After appropriate counselling, offer **prostate specific antigen (PSA) test** and **digital rectal examination** to assess for prostate cancer in patients with any lower urinary tract symptoms including:
  ● Nocturia ● Urinary frequency ● Hesitancy ● Urgency or retention ● Erectile dysfunction ● Visible haematuria
- Where the result is just below the age-specific threshold, consider repeating the PSA test after one month. A number of decision support tools are available to assist patients in deciding whether to proceed with a PSA test (see references).
- **Asymptomatic men with a life expectancy of clearly less than 10 years should be recommended against an initial or repeat PSA test as they are unlikely to benefit**.

The GP should ensure that **up to date (within 3 months) eGFR / renal function,** imaging reports and other relevant investigations are available for the specialist when the patient is seen. Please also let the team know if patient is not suitable for MRI (e.g. has a pacemaker). This will enable the urology team to assess the patient's suitability or not for **straight to test** pathway**.**

Prostate: Referral Criteria

- PSA level is above the agreed age-specific reference ranges **and UTI excluded**
- PSA levels remain above London agreed age-specific reference ranges 8 weeks **after treatment for UTI**
- PSA level > 20 (even in presence of UTI)
- Prostate feels malignant on digital rectal examination

Elevated Age Specific PSA Levels (NICE)	
Age	PSA level
Below 40	Use clinical judgement
40–49	More than 2.5
50–59	More than 3.5
60–69	More than 4.5
70–79	More than 6.5
Above 79	Use clinical judgement

Prostate cancer: Risk Factors

- Patients with a prostate over 50, and risk increases with age (average age of diagnosis:70-74 years)
- Parent or sibling with either prostate or breast cancer and with increasing risk if relative was less than 60 years old when diagnosed or are BRCA1/2 carriers.
- Patients with ethnicities listed as 'Black African', 'Black Caribbean' and 'Black Other' have a 1 in 4 lifetime risk of prostate cancer.

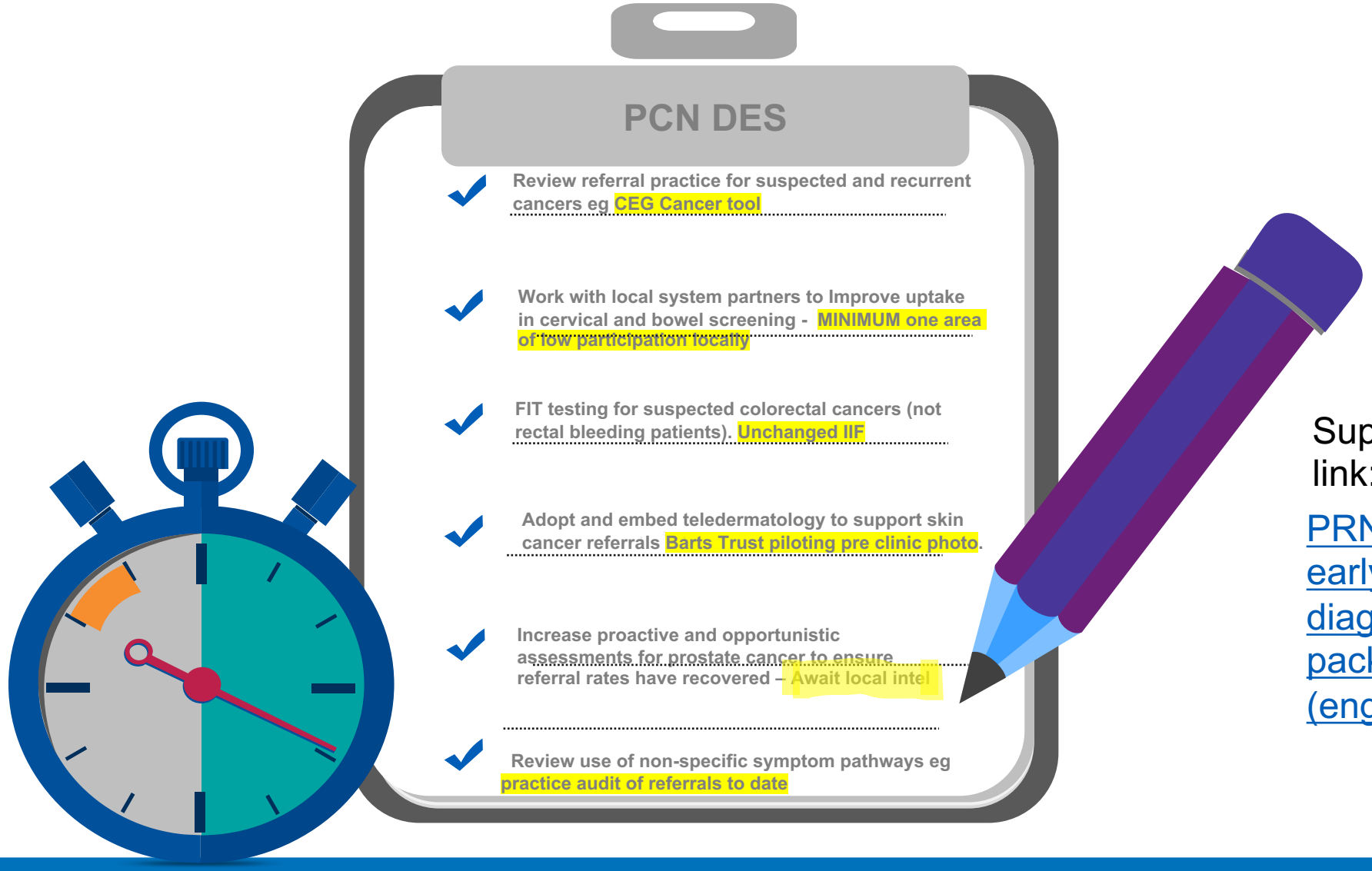
Safety netting: The GP has clinical responsibility for ensuring appropriate follow up and onward referral is arranged for patients referred on direct access investigations. In many cases positive results may be forwarded directly to the cancer team but the GP must ensure a referral has been made and that appropriate safety-netting arrangements are in place.

SUSPECTED UROLOGICAL CANCER REFERRAL

For Testicular, Bladder, Penile and Renal cancer, please see over

document updated June 2022

Early Cancer Diagnosis PCN DES Requirements 2023/2024



Support pack link:

[PRN00157-ncds-early-cancer-diagnosis-support-pack.pdf (england.nhs.uk)]

1. Review Referral Practice

- Review of new diagnoses – learning

  1. Remember cancer in differential for non-specific presentations even in young people - haematological, lung, rare (carcinoid)

  2. Remember ovarian ca in women with bowel/bladder changes, and endometrial ca in older women with haematuria (if doing urology 2ww please also do urgent pelvic USS)

  3. Investigate persistent symptoms e.g. headache – nasopharyngeal ca on CT scan, skin rash – cutaneous T-cell lymphoma. Consider electronic safety net for symptoms – follow up

Learning continued

4. Document a full systems review for anyone with weight loss, anorexia, or children with a concerning symptom

5. Remember people with cancer can get 2nd cancers (higher risk)

6. Importance of electronic safety net for diagnostic tests – also for repeat tests e.g. inconclusive USS

7. Don't rely on text message to reach patients with abnormal results

- Other methods – audit use of safety net tools, review all referrals into a specific tumour site e.g. lung, lower GI

2. Contribute to efforts to improve uptake of cervical and bowel ca screening, targeting those with low participation

- Participation consistently low for LD women and smears

  Please review your LD women including those who've been exception reported; Easy Read resources are available, also Jo's Trust video.

  https://www.csas.nhs.uk/support/ - scroll down for info on how to cease women who lack capacity to consent (can also defer due to pregnancy)

- Participation low in patches for LD bowel and SMI bowel and cx
- Youscreen (self swab) – study hopefully published soon, DOH carrying out additional research to help determine national strategy
- https://mybodybackproject.com/cervical-screening-clinics/ service for women who've experienced sexual trauma

3a. Embed FIT for patients being referred on a LGI 2ww

- NEW JOINT guideline – IMPORTANT (good 30min video)

  https://www.bsg.org.uk/clinical-resource/faecal-immunochemical-testing-fit-in-patients-with-signs-or-symptoms-of-suspected-colorectal-cancer-crc-a-joint-guideline-from-the-acpgbi-and-the-bsg/

- <10 DOES NOT mean Negative for CRC - NEW : call it “less <10”
- 10% bowel cancer patients will have FIT <10
- Main concern is false reassurance
- Do not exclude referral JUST based on the test – clinical trumps ALWAYS
- Younger patients are getting CRC - do they need a FIT test?
- Safety netting for ANY FIT request crucial
- CHECK YOUR LGI referrals – need FIT unless rectal mass/ulceration- covered by Impact/investment Funding – all >80%
- ColonFlag = An AI learning algorithm using age, sex, blood count indices to predict risk + need for assessment e.g. scope. Barts/Alliance plan a service review to check all those with a FIT <10, and inform practice if identified as higher risk with suggestion to refer to MDRAC for scope (if appopriate). However, timescale for this is 6-8 weeks after FIT result is available. Plan to go live in August 23.

- **3b. Engage with teledermatology**
- **4. Increase assessment for prostate cancer in groups where referral rates haven't recovered** – data awaited

  Proactive reach out to black men aged 50-70 with no recent PSA and no CI diagnosis (existing prostate ca, terminal illness)
- **5. Review use of MDRAC (non-site specific pathway)**

  Overall good experience of using the service. Ensure initial tests are done in community

Gateway C – good modules on Non-site specific ca and early diagnosis prostate ca

Jessica Lewsey – PCN Facilitator

Barts Health NHS Trust

The
Non Site Specific Pathway
Rapid Diagnostic Clinic
Royal London Hospital

2WW Multidisciplinary Rapid Access Clinic (MDRAC)

Presenter: Chris Sivell

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Core tests 3 months prior to referral

- FBC
- ESR/CRP
- U&E with eGFR
- LFTs
- TFTs
- HbA1c
- Bone profile
- CA125 or PSA
- CXR
- Urine
- FIT

Additional Tests

- USS
- B12/Ferritin/Folate (if anaemic)
- TTG AB (if anaemic)
- GGT
- HIV
- Clotting
- Glucose
- LDH

How to refer

- Referrals can be made through e-RS by selecting **2WW multidisciplinary rapid access diagnostic clinic** (RLH) –found under 2ww and ‘cancer of unknown primary’
- Patients may be excluded if:

1. They meet the criteria for a site specific 2ww pathway
2. The patients is too unwell or unable to attend for appointments and investigations
3. The patient requires an acute admission
4. They are already being investigated for the same issue by another team

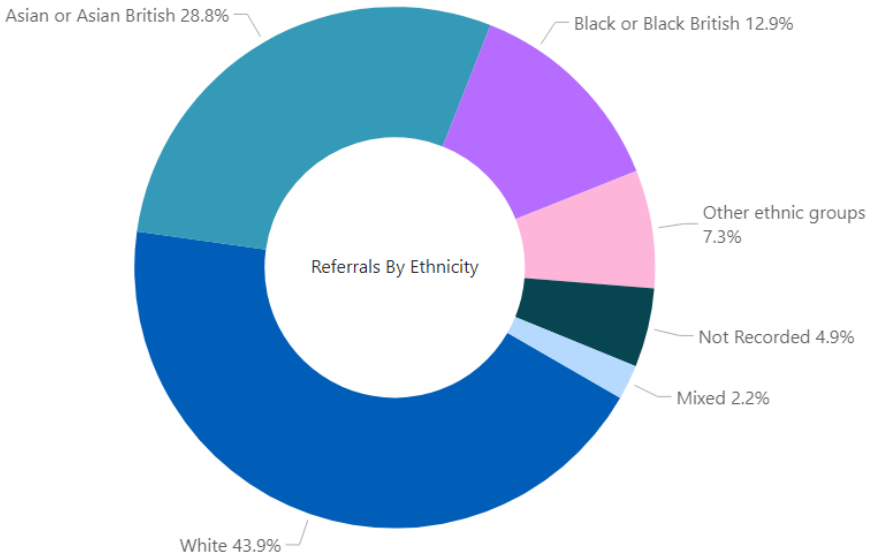
Further information

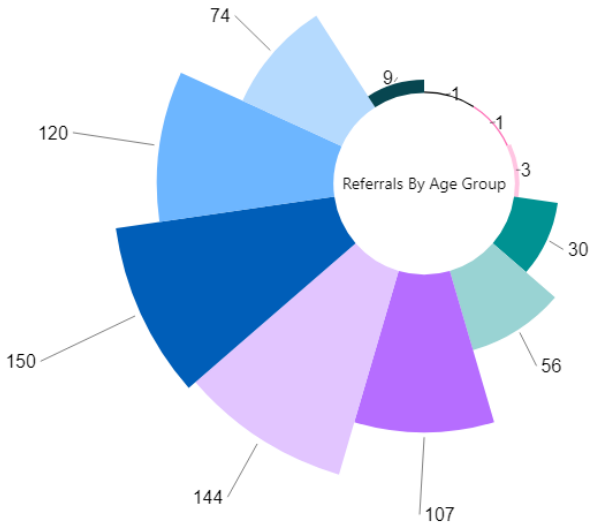
- All information can be found on our website under “Information for Professionals” (also accessible to patients):
- Multidisciplinary Rapid Access Diagnostic Centre (MRADC) (bartshealth.nhs.uk)

- Contact details: 07715 805 112
  bhnt.rapidaccessdiagnosticclinic@nhs.net

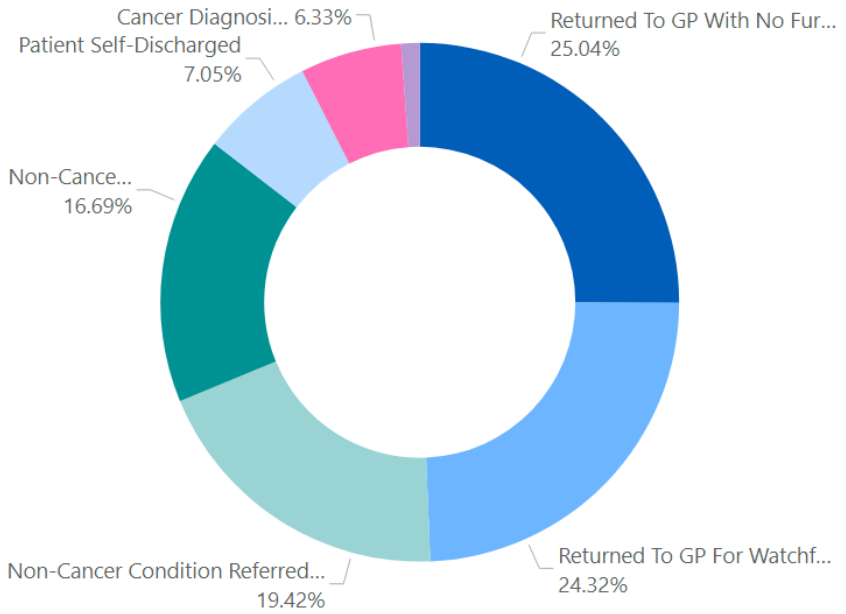
Outcomes 2021-2022

- Received around 695 referrals (99.6% accepted). 41% male 59% female





- Around 6.3% of patients diagnosed with cancer and 16% diagnosed with Non-Cancer conditions (GP) and 19% referred to secondary care



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Serious Benign Conditions	
Large Vessel Vasculitis	Haemochromatosis
Hashimoto Thyroiditis	Sjogren Disease
Polymyalgia Rheumatica	Lyme's Disease
Hyperthyroidism	Wernicke's Encephalopathy
Hypothyroidism	Psychosis
Primary Hyperparathyroidism	Retroperitoneal Fibrosis
Rheumatoid Arthritis	Uterine Fibroids
Spondylarthritis	Milk Alkali Syndrome
Alanto-axial arthropathy	Hepatitis C
Learning Disability	HIV
Tuberculosis	Cannabis Hyperemesis
Frailty	Discitis
Anorexia/Bulimia	Cardiac Block Junctional Rhythm
Atrial Fibrillation	Pulmonary Embolism
Meningioma	Alcoholic Liver Cirrhosis
Unstable Spinal Fractures	Spinal stenosis
Degenerative Spinal Cord Compression	Parkinson's Disease
Fibroadenoma	Adrenal Adenoma
Iron Deficiency Anaemia	Barrett's Oesophagus
Benign Prostatitis	Uterine Prolapse

Feedback

“The patient was singing your praises and were very impressed with your clinic/work-up”

From a Consultant Haematologist

“I am grateful for your genuine concern and kindness”

From a patient with complex symptoms

“Thank you for all your help and kindness… I will be eternally grateful for your hard work in getting to the bottom of what was wrong with me”

RDC Patient

How can we work better together ?

- GP history/ opinion is invaluable
- Let patients know GP concern of cancer hence referral
- Filter test and FIT in community
- Prompt letters from us, as timely as possible
- Prompt email dialogue with us, if you would like to discuss a patient prior to referral, or require further information

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PLT Presentation (CEG)

6th July 2023

Karishma Bhuruth– Clinical Facilitator
Clinical Effectiveness Group (CEG)

CEG Cancer Diagnosis Audit Tool

Reflective tool:

- Supports reflection on new cancer diagnoses
- Can help identify any avoidable delays
- Useful for Early Cancer Diagnosis DES

Cancer Diagnosis Audit Tool

Select Clinical System: EMIS / SystmOne — Press to locate CSV — Export to xlsx — Please contact your local cancer clinical lead for any queries. chnical queries: Karishma Bhuruth (k.d.bhuruth@qmul.ac.

Practice Name: Abernethy Medical Centre (F88888)

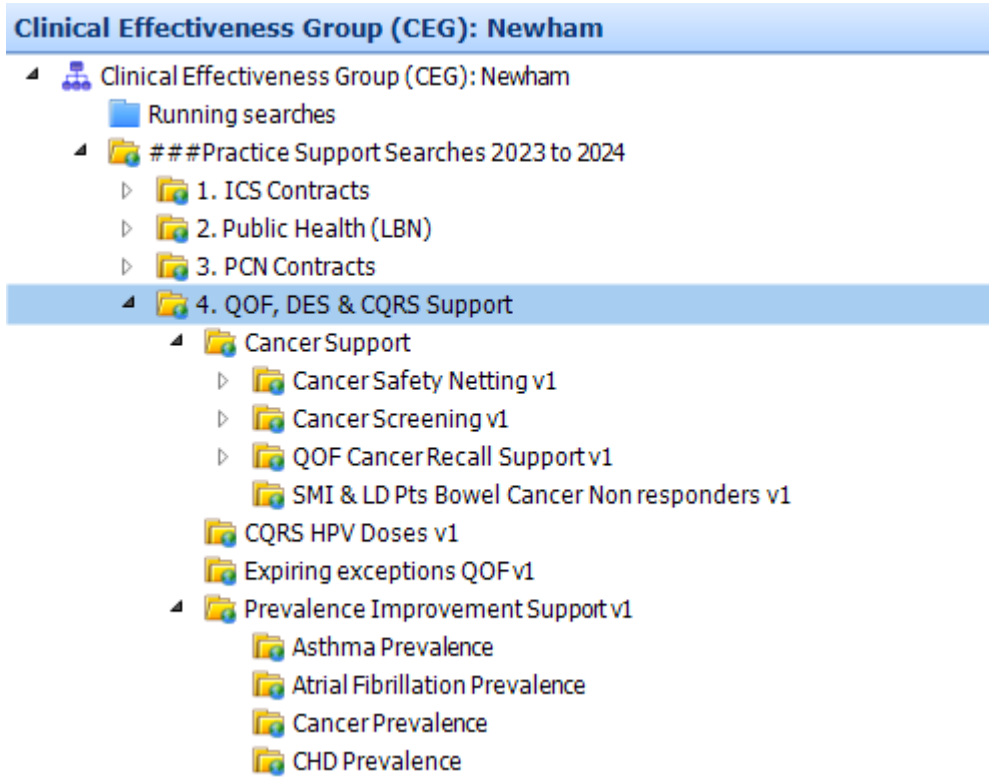
This tool is to be used to help clinicans to reflect on their cancer patients and specifically review if there were any avoidable delays to diagnosis of their cancer.

All fields are mandatory

Quarter 1 (1st April- 30th June) 2022/2023

Emis no.	Full Name	DoB	Gender	Deprivation Quintile (1 = most)	Ethnicity	Housebound	Dementia	SMI	Learning Disabilities	Cancer Diagnosed – New (Check it's not recurrence/secondary)	Date of diagnosis	Age at diagnosis	Tick this box to indicate recurrent diagnosis	What was the stage at diagnosis?	Current Tumour Group	Does this patient have any problems communicating? Or have any language or advocacy needs? If so please
123451	EMIS, Test (Mr)	01/Jan/1950	Male	2	Pakistani or British Pakistani – ethnic category 2001 census	Housebound patient review				Malignant tumour of prostate	09/May/2022	72	☐			
123452	TRANSFER, Test (Mr)	01/Jan/1959	Male	4	Pakistani or British Pakistani – ethnic category 2001 census					Malignant tumour of prostate	12/Apr/2022	63	☐			
123453	TEST, Minnie (Mr)	01/Jan/1971	Male	1	Caribbean – ethnic category 2001 census					Malignant tumour of prostate	01/Apr/2022	51	☐			
123454	TEST, Fred (Mrs)	01/Jan/1980	Female	1	Bangladeshi or British Bangladeshi – ethn categ 2001 census	Temporarily housebound				Carcinoma of breast	16/May/2022	42	☑			
123455	CREE, Test (Mrs)	01/Jan/1960	Female	2	Caribbean – ethnic category 2001 census					Malignant neoplasm of female breast	11/May/2022	62	☐			
123456	EMIS, Test (Ms)	01/Jan/1970	Female	2	Pakistani or British Pakistani – ethnic category 2001 census					Bony metastasis	04/Apr/2022	52	☐			
123457	ALPH, Test (Ms)	01/Jan/1979	Female	2	Pakistani or British Pakistani – ethnic category 2001 census					Malignant tumour of breast	13/Jun/2022	43	☑			
123458	BETA, Test (Ms)	01/Jan/1960	Female	2	Other Black background – ethnic category 2001 census					Malignant tumour of sigmoid colon	05/May/2022	62	☐			
123459	TRANSFER, Test (Ms)	01/Jan/1962	Female	1	White and Black African – ethnic category 2001 census	Housebound				Breast cancer	09/Jun/2022	60	☐			

CEG Support Searches & Templates



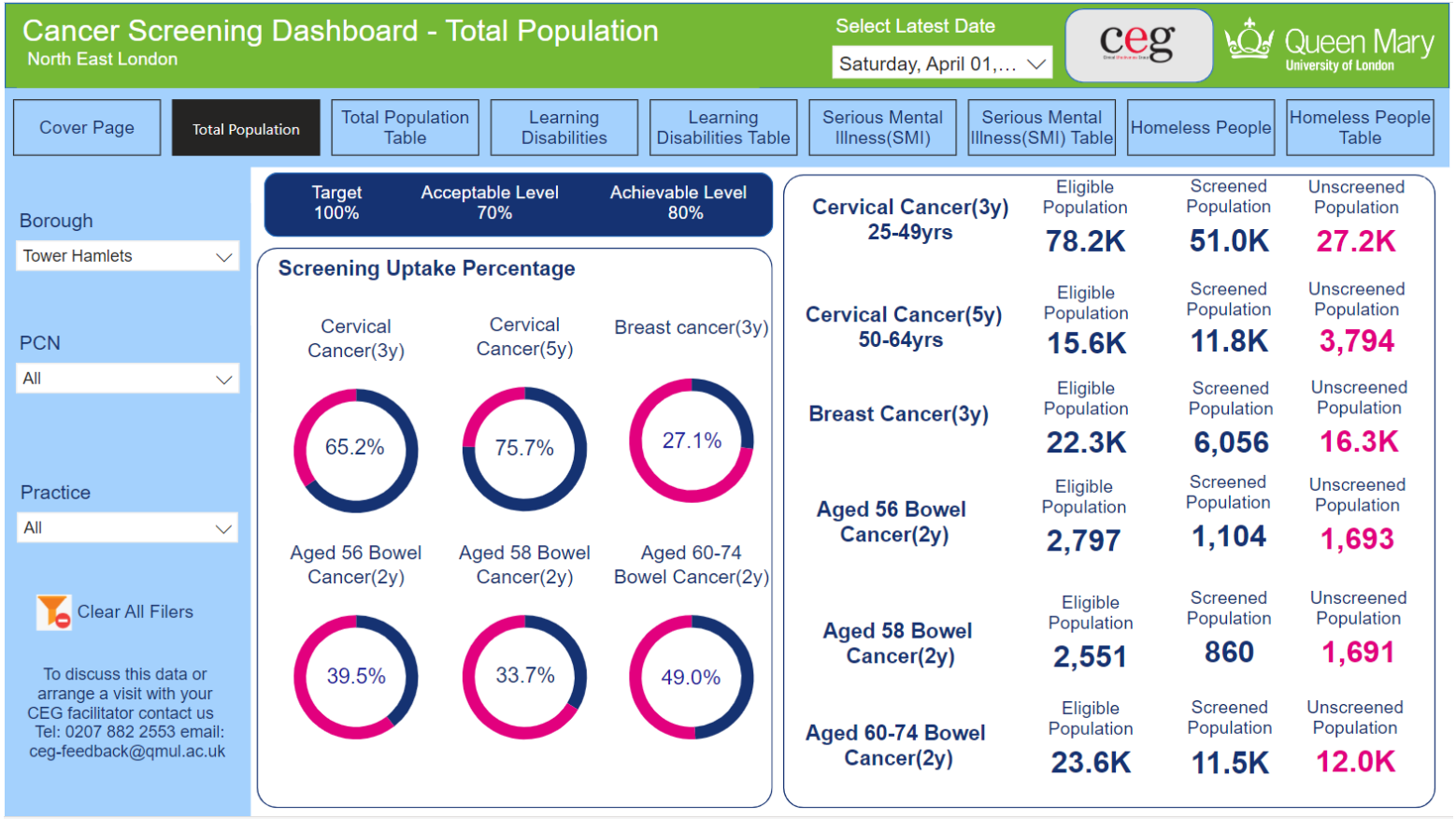
Womens Health CEG
(incl Bowel and Cervical Screening)

Cancer Referral and Safety Netting
(Optional)

LTC and SNS CEG

CEG Dashboards

Cancer Screening Dashboard (monthly)



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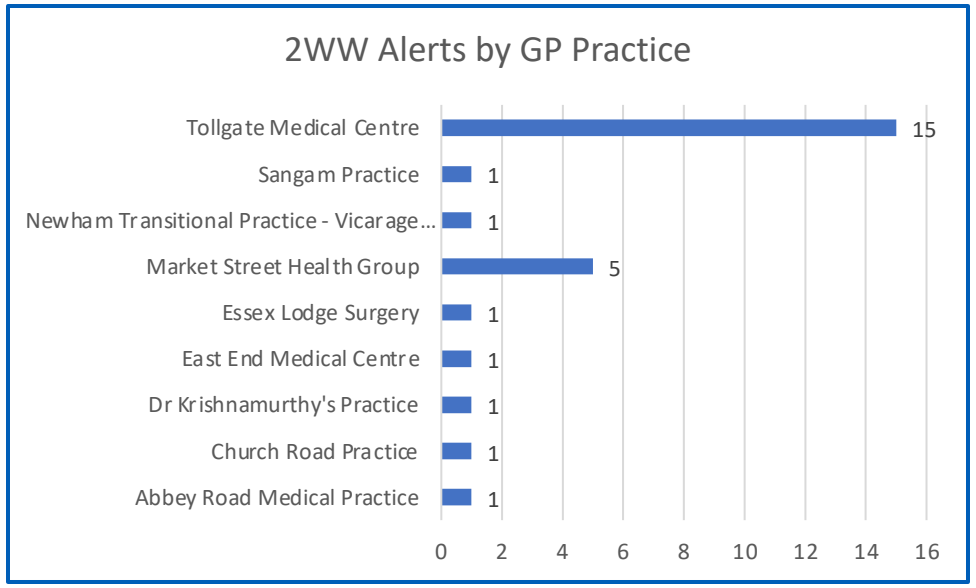
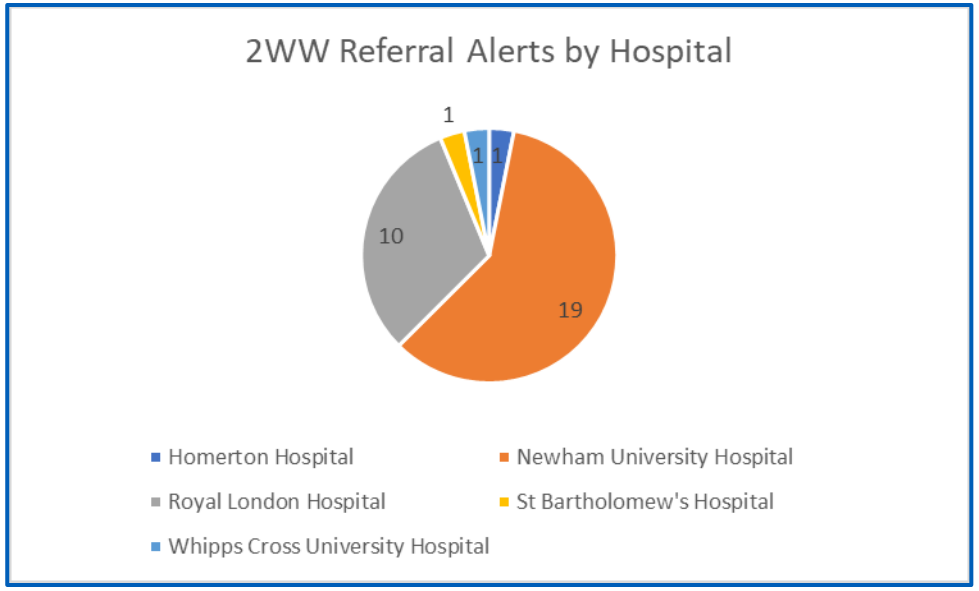
Cancer PLT Newham 06/07/23

Katherine Mutsvangwa- Newham Quality Lead

Newham Place Based Partnership

Newham GP Cancer Alerts submitted between June 2022 and May 2023





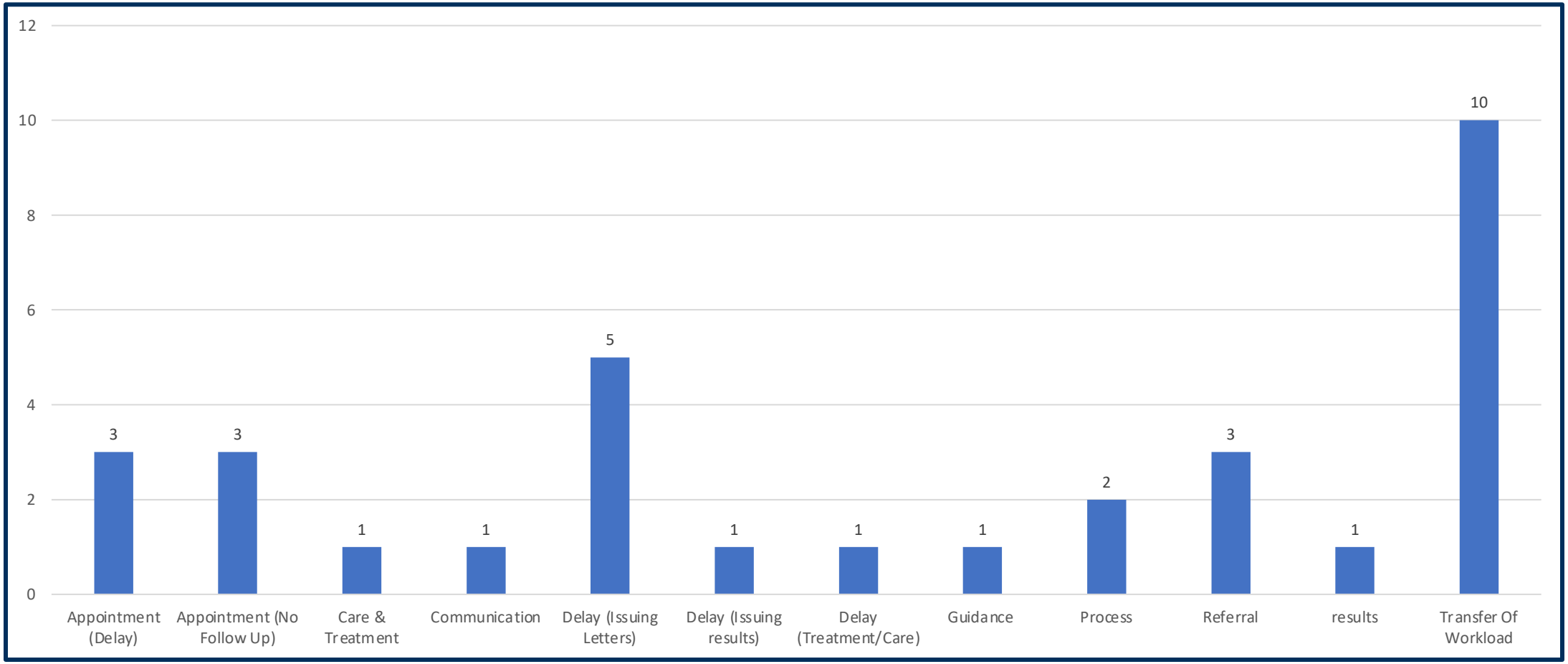
Alerts by GP Practices

- There were 32 alerts related to 2ww reported between June 2022 and May 2023
- Most were reported by Tollgate Medical Centre and Market Street Health group.

Alerts By Hospital site

- Mostly from Newham University Hospital and Royal London Hospital

Number of Alerts involving cancer services submitted between June 2022 and Mary 2023 (1 Year) split by NUH, RLH, WX and SBH, by alert theme



How to raise a Service Alert

How do I raise a Service Alert?

1. To raise a service alert (EMIS Users), the primary care clinician will:

2. Access the corresponding patient file via EMIS

3. Search for ‘Service Alert’ form in EMIS Resource Publisher

Complete all the fields within form and save.

- Consent: Service Alert Forms will not be rejected if left incomplete on the basis of legitimate interest.
- Request for further information: A response is required within 2 weeks of request. If no response is received, the Practice will be notified of the closure of the alert via email.

4. Download the completed ‘Service Alert’ form

5. Send the completed form to **nelondonicb.welservicealerts@nhs.net**

6. Wait for the corresponding response within 13 working days

Horizon Scanning – revised service alert process due in Q1

Success Stories from Service Alerts

- Recall of patients whose PSA reference ranges were outside of PAN London guidance
- Recommendation to centralise urgent suspected cancer booking team across Barts Health
- Review of local SOP's to support FIT referral process to eliminate rejected referrals with no FIT
- Current review of A&R process where cancer is suspected
- Review of processes at Barts and practices where referrals are not attached on eRS

North East London Cancer Alliance

Saira Parker-Deeks, Programme Manager – saira.parker-deeks@nhs.net

Early Diagnosis

Raising awareness of signs and symptoms; increasing uptake of national screening programmes; working with and supporting local doctors; using the latest innovation in cancer diagnosis.

Faster Diagnosis and Operational Improvement

Reducing the backlog; reducing waiting times; improving cancer patient pathways; improving performance against national cancer standards.

Treatments and Personalised Care

Reducing variation; supporting the establishment of the new Children, Teenage and Young Adult Operational Delivery Networks; improving quality of life for cancer patients.

NHS
North East London
Cancer Alliance

In 2023/24 we will:

- Introduce a community of practice with cancer GP leads
- Establish input and engagement from primary care at delivery groups and ERGs across NEL
- Develop and implement a primary care cancer education programme for all staff
- Improve and expand GP direct access diagnostic pathways
- Develop a clear set of actions and milestones to support the Early Diagnosis PCN DES
- Focus on quality improvement for cancer care reviews in primary care

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slido.com

#PLTCancer

Barts Health and TNW Update for Primary Care
August 2021

GP Direct Access to CT for Suspected Pancreatic Cancer

We are writing to update you on GP access to urgent direct investigations for suspected cancer at Barts Health. As you may know, NICE guidelines (NG12; Suspected cancer: recognition and referral) recommended that GPs consider referring patients directly for urgent (within two weeks) investigations in specific clinical situations. The imaging departments across Barts Health will make this service available from 01 September 2021 providing equitable access to NG12 diagnostics across London.

Radiology Process and Safety Netting

You will be able to request an urgent CT abdomen & pelvis for suspected pancreatic cancer via T-quest. For those practices using C the Signs (in Newham and Waltham Forest) this will be included within the risk assessment and recommendations.

GPs should only request an investigation urgently if the patient meets the NICE criteria. Radiology services are under considerable strain, and a request to undertake a test within two weeks should be clearly justifiable on clinical grounds.

- Consider an urgent direct access CT scan (to be performed within 2 weeks) to assess for pancreatic cancer in people aged 60 and over with weight loss **and** any of the following:
  - diarrhoea
  - back pain
  - abdominal pain
  - nausea
  - vomiting
  - constipation
  - new-onset diabetes. **[2015]**
- The order is built into T-quest with a description of " CT Pancreas NICE NG12" and will only be visible for patients 60 and over.
- Patients must have a recent serum creatinine within the last 3 months, please include the result and date of the test in the clinical details box.
- If you have any queries about requesting this diagnostic test, please email the Radiology team for further information and advice.

Tower Hamlets:	bartshealth.imagingadviceandsupportrlh@nhs.net
Newham:	Radiology.gpsupport@nhs.net
Waltham Forest:	Bartshealth.imaging-appointments@nhs.net

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slido.com

#PLTCancer

Quality Cancer Care Reviews

QOF : - Register of patients (5 pts)

- The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis (6 pts) AIM TO INVITE AT 8 MONTHS
- The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis (2 pts)

Consider Accurx Florey use – Cancer Care review (Macmillan printable version also if patient prefers)

- helps patients & clinicians pre CCR to identify unmet needs and priority areas for patients

DON'T FORGET : Cancer Care Navigators (CHS form) and Social prescriber signposting

Common SE of Cancer Treatment

- **Fatigue**
- **Insomnia**
- **Anxiety and depression** – psychosocial disruption

- **Chemotherapy** –induced peripheral neuropathy. Difficult to treat. Duloxetine may be good choice if also mood issues or other pain

- **Radiotherapy** – damages the vascular bed within the field of treatment, increased risk of later ischaemic disease

Longer term consequences

- **Osteoporosis** – especially after hormonal treatment e.g. breast, prostate ca
- **Cardiac** – from chemo or radiotherapy. IHD, Hypertension, arrhythmias, cardiomyopathy
- **Gastrointestinal** – from chemo or radiotherapy. Commonly diarrhoea, can have major impact on QoL. Multiple factors - colitis, telangiectasia, secondary lactose intolerance, bile acid malabsorption
- **Fertility and sexual function** – especially after pelvic surgery or radiotherapy
- **Higher risk of a second malignancy**

Speaker Contact Information

Name	Title/Work Area	Email Address	Organisation
Helen Stedeford	Newham GP Clinical Lead for Cancer	helenstedeford@nhs.net	Newham Place
Karishma Bhuruth	CEG Clinical Facilitator	k.d.bhuruth@qmul.ac.uk	CEG
Jessica Lewsey	Cancer PCN Facilitator	jessica.lewsey@nhs.net	Community Links
Urgent Barts 2WW/Cancer Queries	Barts Cancer Team	BHNT.WaitingTimesInfo@nhs.net	Barts Health
Chris Sivell	Advance Nurse Practitioner	bhnt.rapidaccessdiagnosticclinic@nhs.net chris.sivell@nhs.net	Barts Health
Katherine Mutsvanga	Quality Lead Newham	k.mutsvangwa@nhs.net	NEL ICB
Saira Parker-Deeks	Programme Manager, Primary Care	saira.parker-deeks@nhs.net	NEL Cancer Alliance

Website Resources

Resource Name	Link
CEG Resources	Cancer diagnosis and care - Clinical Effectiveness Group (qmul.ac.uk)
NEL Cancer Alliance Website for Primary Care	https://www.nelcanceralliance.nhs.uk/primary-care
Pan London Referral Forms for Suspected Cancer	Pan-London suspected cancer referral forms - Transformation Partners in Health and Care Partnership
New joint guidance on FIT	Faecal immunochemical testing (FIT) in patients with signs or symptoms of suspected colorectal cancer (CRC): a joint guideline from the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the British Society of Gastroenterology (BSG) - The British Society of Gastroenterology
RDC	Multidisciplinary Rapid Access Diagnostic Centre (MRADC) (bartshealth.nhs.uk)
PCN DES Support Pack	PRN00157-ncds-early-cancer-diagnosis-support-pack.pdf (england.nhs.uk)
Macmillan's Cancer Care reviews Resource	https://www.macmillan.org.uk/healthcare-professionals/cancer-pathways/prevention-and-diagnosis/cancer-care-review
Concerns checklist for patients to prepare for CCR (printable):	https://be.macmillan.org.uk/Downloads/ResourcesForHSCPs/MAC13689ConcernsChecklist17AWweb.pdf

North East London Cancer Alliance

- Primary Care newsletter sent by email
- Website Primary Care | North East London Cancer Alliance (nelcanceralliance.nhs.uk)
- Social media platforms

Twitter:	@CancerNEL
Facebook:	@NELCancerAlliance
Instagram:	@CancerNEL
YouTube:	https://www.youtube.com/@northeastlondoncancerallia1186
LinkedIn:	https://www.linkedin.com/company/north-east-london-cancer-alliance/

To find out more email - nelondonicb.nelcanceralliance@nhs.net

Newham Protected Learning Time Agenda

Thursday 6th July 2023, 14:30 – 17:30

Newham TRAINING HUB
We develop people

	Agenda Items	Lead	Times
1	Spinal Pathways • *Referral pathway to spine* • *What to refer to the spine service* • *Cauda Equina and MSCC pathway*	**Phil Barber** - Advanced Physiotherapy Practitioner & Clinical Pathways Lead (NE London and Essex Spinal Network)	14:30 – 15:00
2	MSK Self-Management App	**getUbetter Team**	15:00 – 15:15
3	Break		15:15 – 15:20
4	Cancer • *Update on new urgent suspected cancer referral forms* • *PSA reference changes and Colon Flag* • *Early Diagnosis DES: learning so far and next steps* • *Non-site specific cancer pathway* • *CEG resources* • *Quality issues and service alerts*	**Dr Helen Stedeford** - Newham Clinical Lead Cancer	15:20 – 16:20
5	Break		16:20 – 16:30
6	CKD • *Management of CKD - "3 within 3"* • *New therapies for CKD* • *Useful resources for CKD management*	**Ademola Olaitan -** vCKD Newham	16:30 – 17:30

CKD

Dr Ademola Olaitan

Consultant Nephrologist

Barts Health NHS Trust

Outline

- Definition
- Risk stratification
- Aims of Management
- Resources
- Questions

CKD

- Abnormality of kidney function or structure
- Present for > 3 months
- Includes those with eGFR <60
  - On at least two occasions
  - Separated by at least 90 days

CKD

- Abnormality of kidney function or structure
- Present for > 3 months
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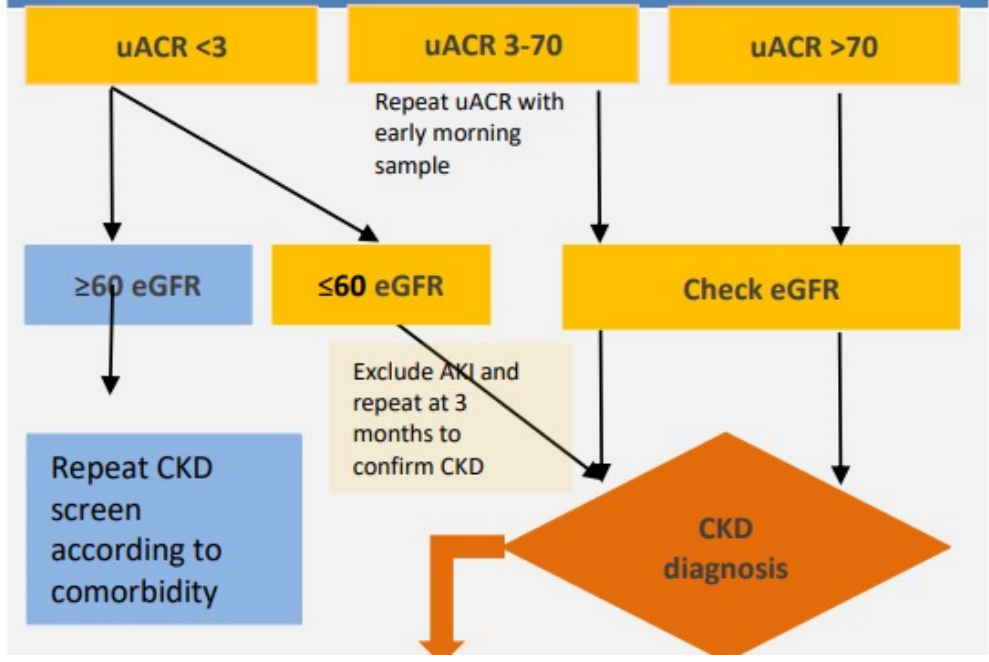
  - Separated by at least 90 days

WHO SHOULD BE TESTED FOR CKD

Offer testing for CKD using eGFR, serum creatinine and urinary ACR to people with any of the following risk factors:

- Diabetes - yearly
- Hypertension – every 1-5 years, yearly if BP uncontrolled
- Cardiovascular disease (ischaemic heart disease, chronic heart failure, peripheral vascular disease or cerebral vascular disease)
- History of acute kidney injury (monitor yearly for 3 years even if function back to baseline)
- Structural renal tract disease, recurrent renal calculi or prostatic hypertrophy
- Multisystem disease e.g. systemic lupus erythematosus
- Family history of end-stage kidney disease (GFR category G5) or hereditary kidney disease
- Haematuria
- Treated with nephrotoxic agents (NSAIDS, Lithium, CNI, Sulphasalazines)

CKD diagnosis



~~Measuring~~ Estimating GFR

Serum Creatinine = 200 umol/L

Serum Creatinine = 200 umol/L

~~Measuring~~ Estimating GFR

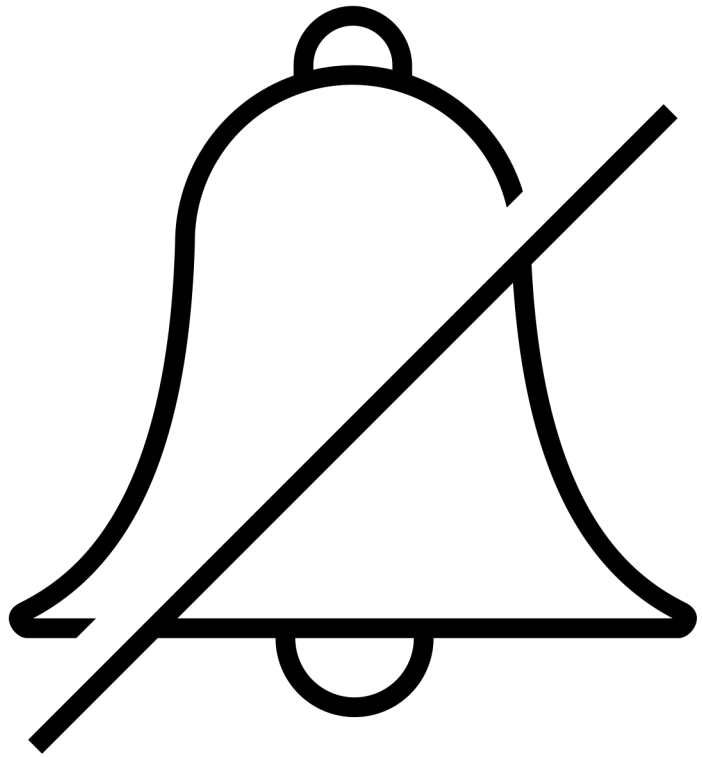
- Caution in body builders, muscle wasting disorders, amputees, severe liver disease, children, pregnancy, extremes of body weight, AKI
- Avoid meat for 12 hours before testing NICE
- Confirm an eGFR result of less than 60 ml/min/1.73 m2 in a person not previously tested by repeating the test within 2 weeks

CKD classification by eGFR & Albuminuria

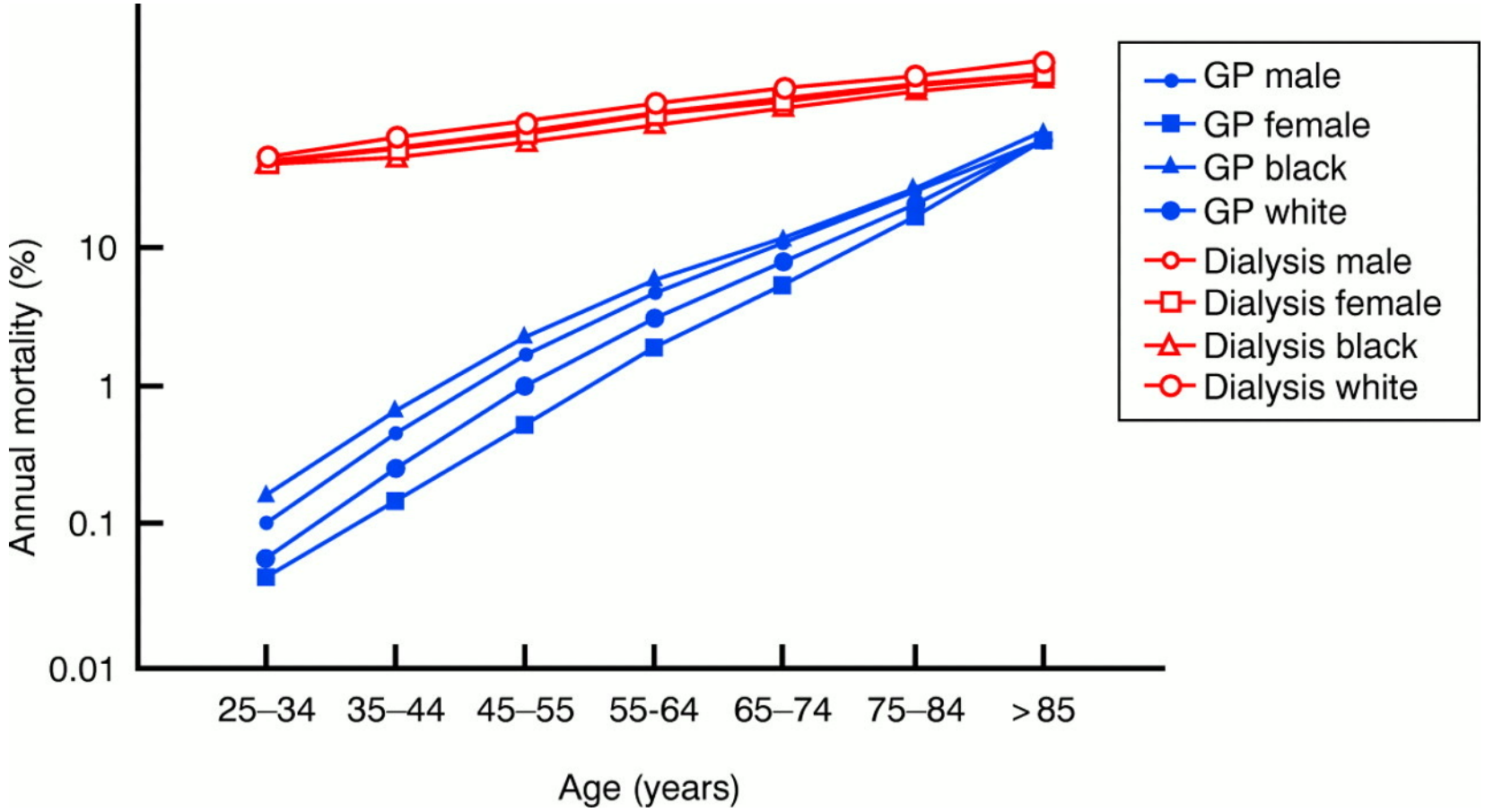
eGFR ml/min/1.73m²	Albuminuria categories		
	A 1 <3 mg/mol	A 2 3-30 mg/mmol	A 3 >30 mg/mmol
G1 ≥ 90	No CKD	G1 A2	G1 A3
G2 60-89	No CKD	G2 A2	G2 A3
G3a 45-59	G3a A1	G3a A2	G3a A3
G3b 30-44	G3b A1	G3b A2	G3b A3
G4 15-29	G4 A1	G4 A2	G4 A3
G5 <15	G5 A1	G5 A2	G5 A3

Increasing risk

CKD workgroup. Kidney Disease Improving Global Outcomes (KDIGO) 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney Inter Suppl 2013;3:1-150



Data from the US Renal Disease Service (USRDS) showing CVD mortality rates in patients on renal replacement therapy compared with normal background population.



Alan G Jardine, and Kevin McLaughlin Heart 2001;86:459-466

Heart

Summary of relative risks from categorical meta-analysis
(dipstick included)
(−, ±, +, ⩾ ++)

All-cause mortality

	ACR <10	ACR 10–29	ACR 30–299	ACR ⩾300
eGFR >105	1.1	1.5	2.2	5.0
eGFR 90–105	Ref	1.4	1.5	3.1
eGFR 75–90	1.0	1.3	1.7	2.3
eGFR 60–75	1.0	1.4	1.8	2.7
eGFR 45–60	1.3	1.7	2.2	3.6
eGFR 30–45	1.9	2.3	3.3	4.9
eGFR 15–30	5.3	3.6	4.7	6.6

Cardiovascular mortality

	ACR <10	ACR 10–29	ACR 30–299	ACR ⩾300
eGFR >105	0.9	1.3	2.3	2.1
eGFR 90–105	Ref	1.5	1.7	3.7
eGFR 75–90	1.0	1.3	1.6	3.7
eGFR 60–75	1.1	1.4	2.0	4.1
eGFR 45–60	1.5	2.2	2.8	4.3
eGFR 30–45	2.2	2.7	3.4	5.2
eGFR 15–30	14	7.9	4.8	8.1

Kidney failure (ESRD)

	ACR <10	ACR 10–29	ACR 30–299	ACR ⩾300
eGFR >105	Ref	Ref	7.8	18
eGFR 90–105	Ref	Ref	11	20
eGFR 75–90	Ref	Ref	3.8	48
eGFR 60–75	Ref	Ref	7.4	67
eGFR 45–60	5.2	22	40	147
eGFR 30–45	56	74	294	763
eGFR 15–30	433	1044	1056	2286

Acute kidney injury (AKI)

	ACR <10	ACR 10–29	ACR 30–299	ACR ⩾300
eGFR >105	Ref	Ref	2.7	8.4
eGFR 90–105	Ref	Ref	2.4	5.8
eGFR 75–90	Ref	Ref	2.5	4.1
eGFR 60–75	Ref	Ref	3.3	6.4
eGFR 45–60	2.2	4.9	6.4	5.9
eGFR 30–45	7.3	10	12	20
eGFR 15–30	17	17	21	29

Progressive CKD

	ACR <10	ACR 10–29	ACR 30–299	ACR ⩾300
eGFR >105	Ref	Ref	0.4	3.0
eGFR 90–105	Ref	Ref	0.9	3.3
eGFR 75–90	Ref	Ref	1.9	5.0
eGFR 60–75	Ref	Ref	3.2	8.1
eGFR 45–60	3.1	4.0	9.4	57
eGFR 30–45	3.0	19	15	22
eGFR 15–30	4.0	12	21	7.7

Accelerated progression
- 25% ↓ GFR and change in category
- Sustained ↓ GFR 15mls/min

Over 12 months
↑ risk of ESKD

Aims of CKD management

- Identify treatable/reversible causes
- Risk stratification
- Slow progression of CKD
- Prevent cardiovascular morbidity
- Prevent unplanned dialysis

Aims of CKD management

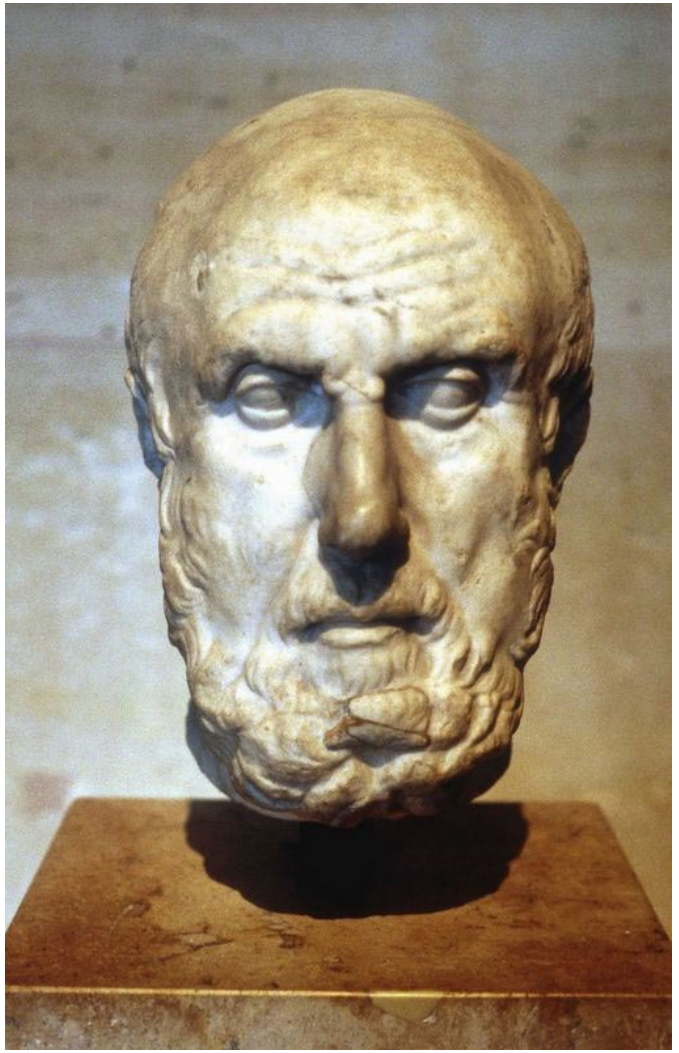
- Identify treatable or reversible causes
  - Diabetes
  - Hypertension
  - Obstruction
  - Medications
  - Myeloma
  - Lupus
  - Age

Aims of CKD management

- Risk stratification

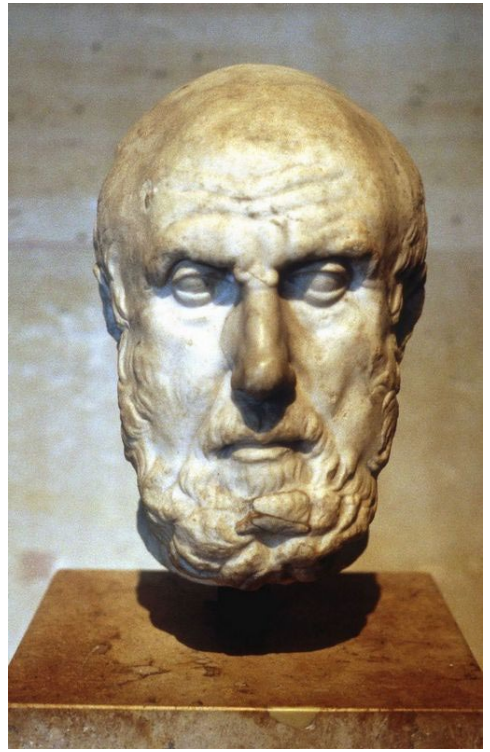
Learn to love urine!

- Very revealing
- Can you tell you a lot in the right hands
- Freely available (usually)
- Urine dip – cheapest diagnostic tool in medicine
- NEVER ignore it!



Urinalysis

- “When bubbles settle on the surface of the urine, they indicate disease of the kidneys, and that the complaint will be protracted.” -- Hippocrates 400 BCE



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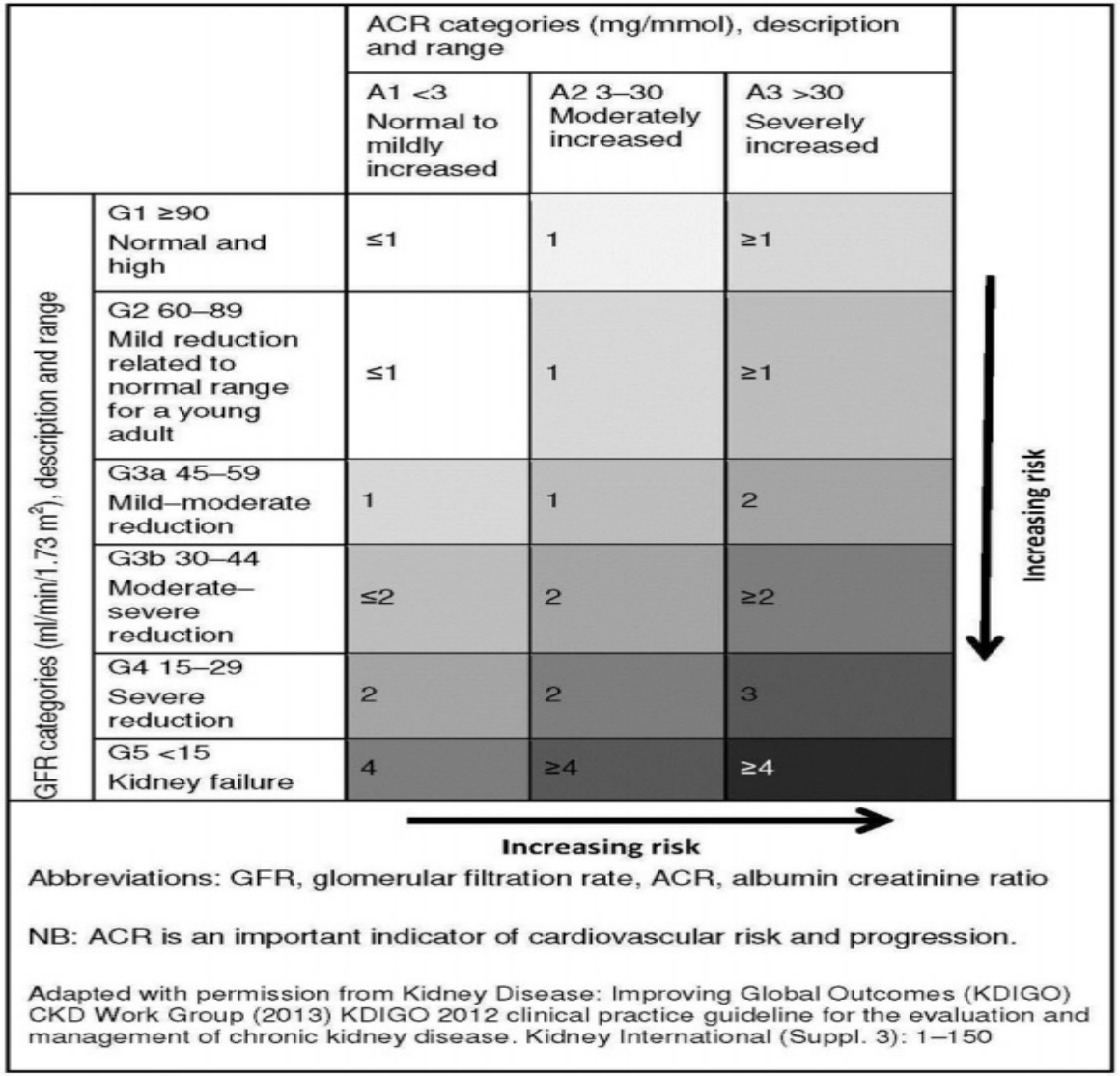
G3b 30-44	G3b A1	G3b A2	G3b A3
G4 15-29	G4 A1	G4 A2	G4 A3
G5 <15	G5 A1	G5 A2	G5 A3

Increasing risk

CKD workgroup. Kidney Disease Improving Global Outcomes (KDIGO) 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney Inter Suppl 2013;3:1-150

Frequency of monitoring



GFR categories (ml/min/1.73 m²), description and range	ACR categories (mg/mmol), description and range		
	A1 <3 Normal to mildly increased	A2 3–30 Moderately increased	A3 >30 Severely increased
G1 ≥90 Normal and high	≤1	1	≥1
G2 60–89 Mild reduction related to normal range for a young adult	≤1	1	≥1
G3a 45–59 Mild–moderate reduction	1	1	2
G3b 30–44 Moderate–severe reduction	≤2	2	≥2
G4 15–29 Severe reduction	2	2	3
G5 <15 Kidney failure	4	≥4	≥4

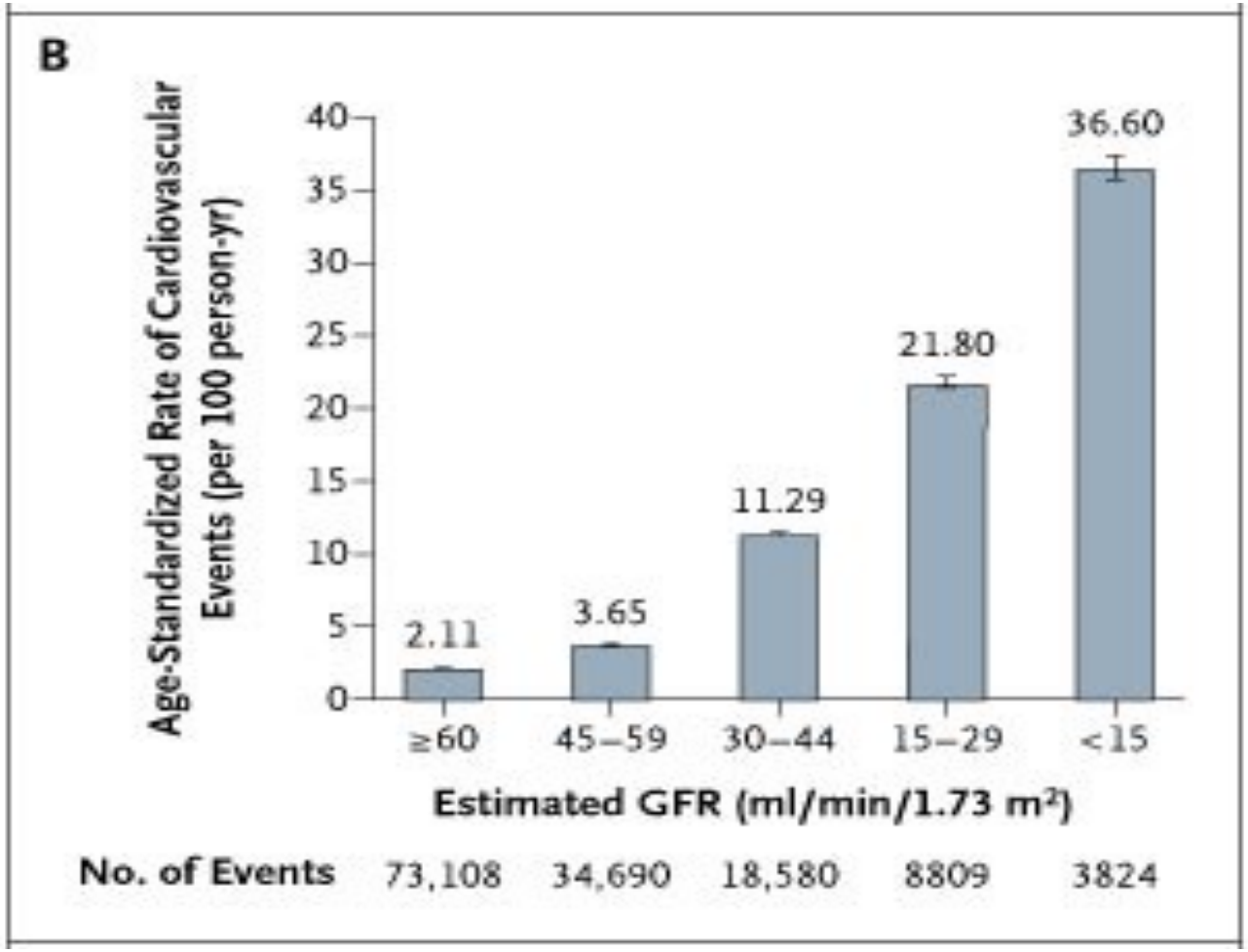
Abbreviations: GFR, glomerular filtration rate, ACR, albumin creatinine ratio

NB: ACR is an important indicator of cardiovascular risk and progression.

Adapted with permission from Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group (2013) KDIGO 2012 clinical practice guideline for the evaluation and management of chronic kidney disease. Kidney International (Suppl. 3): 1–150

NICE

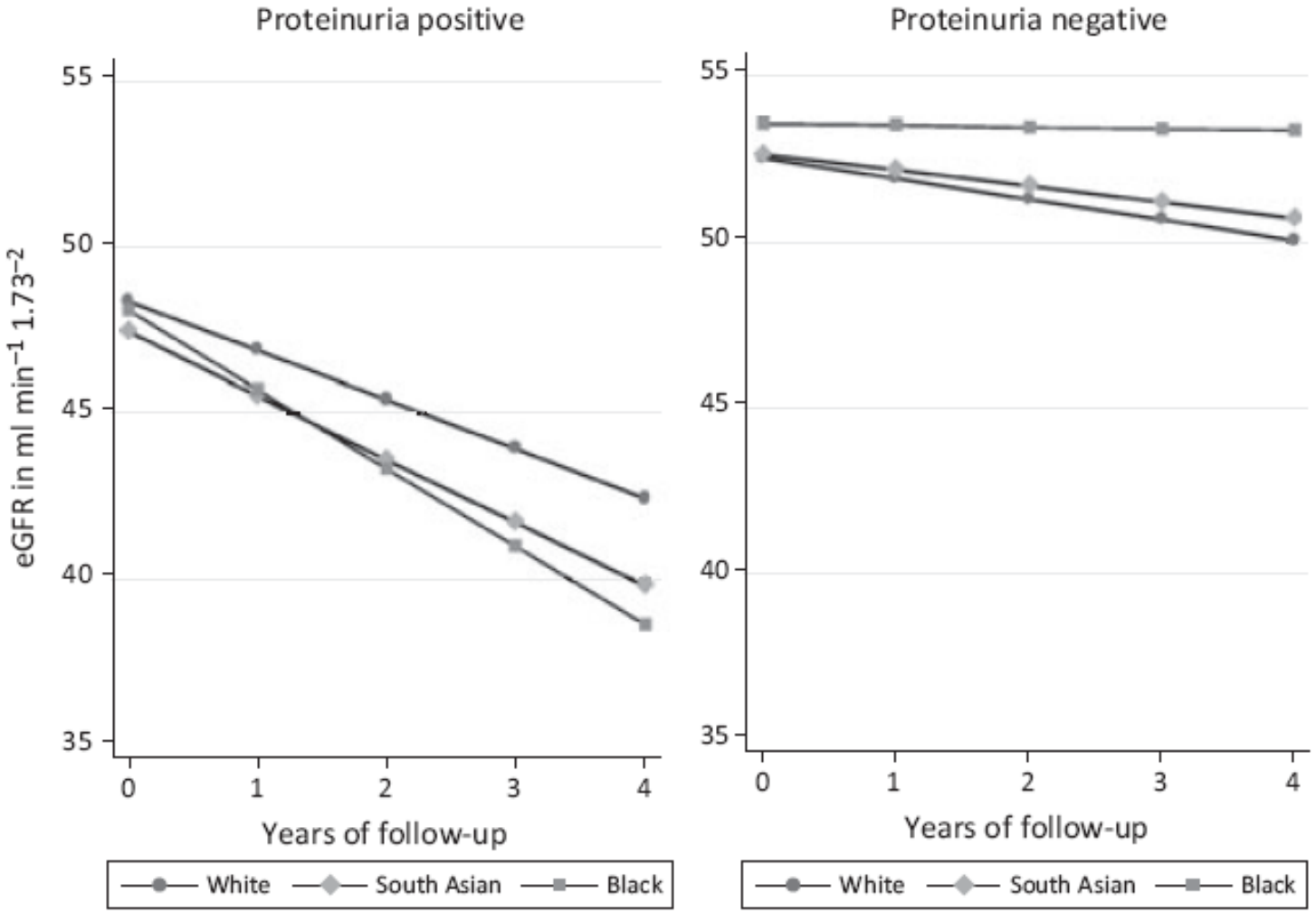
CVD events increase as eGFR falls



Risk factors associated with CKD progression

- Proteinuria

Our local population may be more at risk…

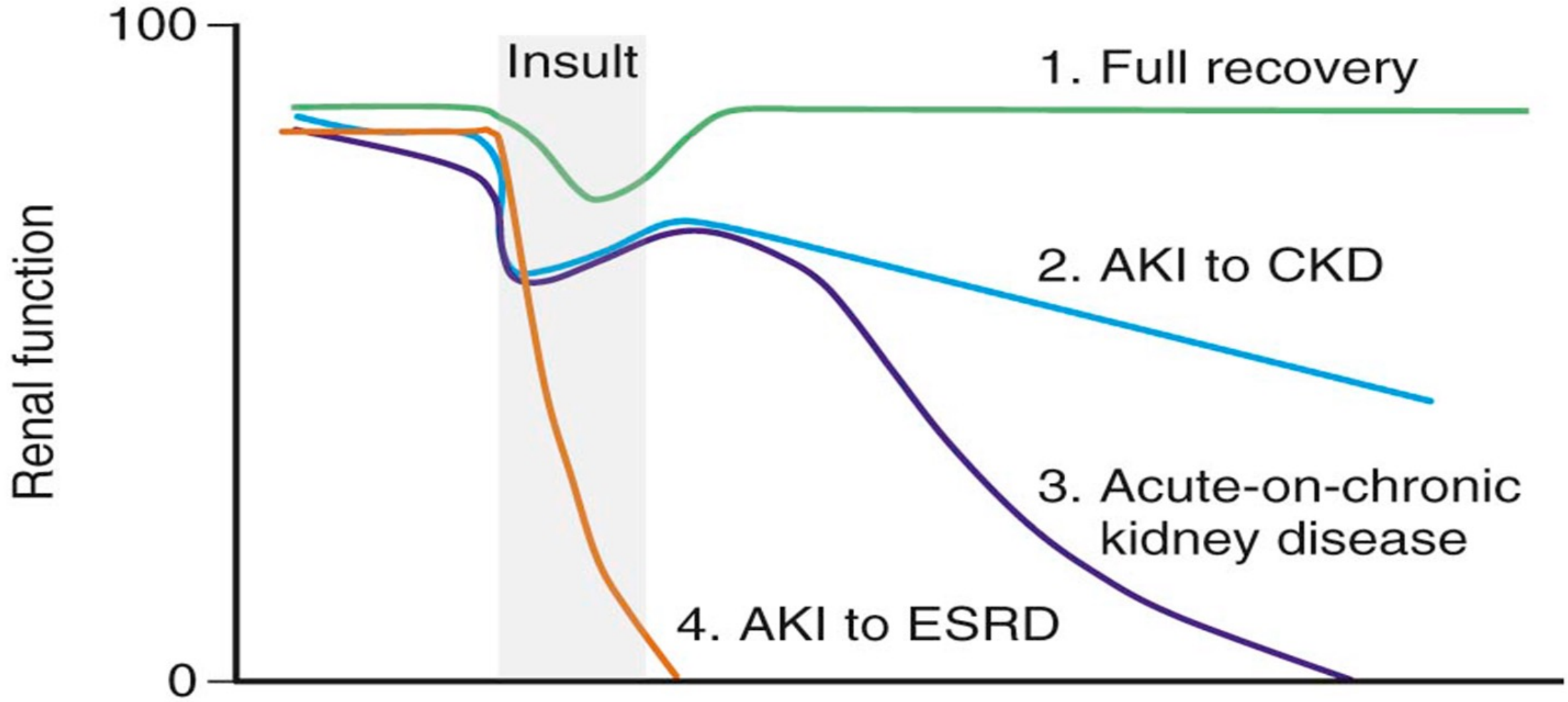


Progression of chronic kidney disease in a multi-ethnic community cohort of patients with diabetes mellitus **Diabetic Medicine** 2013 Dreyer et al

Risk factors associated with CKD progression

- Proteinuria
- Acute kidney injury

Natural History of AKI



Risk factors associated with CKD progression

- Proteinuria
- Acute kidney injury
- Cardiovascular disease
- Hypertension
- Diabetes
- Smoking
- African, African-Caribbean or Asian family origin
- chronic use of NSAIDs
- untreated urinary outflow tract obstruction

Table 1.4. Number of patients starting RRT by renal centre 2011–2016

Centre	Year						Estimated catchment population (millions)[a]	2016 crude rate pmp[b]	(95% CI)
	2011	2012	2013	2014	2015	2016			
England									
B Heart	113	101	100	100	123	135	0.74	183	(152–214)
B QEH	213	208	200	249	245	238	1.70	140	(122–158)
Basldn	44	53	34	45	48	40	0.42	96	(67–126)
Bradfd	60	71	63	83	91	86	0.65	132	(104–160)
Brightn	119	132	139	148	144	150	1.30	116	(97–134)
Bristol	141	149	174	149	146	155	1.44	108	(91–125)
Camb[c]	122	123	136	126	175[c]	120[c]	1.16	104	(85–122)
Carlis	27	19	42	37	46	35	0.32	109	(73–145)
Carsh	207	244	229	265	260	246	1.91	129	(113–145)
Chelms	47	46	47	55	51	53	0.51	104	(76–132)
Colchr	44	29	29	38	28	30	0.30	100	(64–136)
Covnt	110	114	90	126	111	128	0.89	143	(119–168)
Derby	74	80	74	77	64	86	0.70	122	(97–148)
Donc	43	40	61	54	39	62	0.41	151	(114–189)
Dorset	79	73	73	78	75	70	0.86	81	(62–100)
Dudley	43	56	52	42	51	53	0.44	120	(88–152)
Exeter	112	134	100	143	137	143	1.09	131	(110–153)
Glouc	58	75	53	74	72	66	0.59	112	(85–140)
Hull	108	94	90	98	121	93	1.02	91	(73–110)
Ipswi	29	44	40	34	67	42	0.40	105	(73–137)
Kent	120	114	143	148	143	141	1.22	115	(96–134)
L Barts	250	264	283	302	311	297	1.83	162	(144–181)
L Guys	121	130	134	159	179	169	1.08	156	(133–180)
L Kings	137	123	166	148	180	152	1.17	130	(109–150)
L Rfree	220	232	224	230	239	238	1.52	157	(137–177)
L St.G	72	95	85	92	114	94	0.80	118	(94–142)
L West	364	354	303	355	337	385	2.40	160	(144–177)
Leeds	153	151	183	169	147	166	1.67	99	(84–115)
Leic	266	235	288	251	270	324	2.44	133	(119–147)
Liv Ain	58	63	65	65	61	53	0.48	110	(80–139)
Liv Roy	111	104	93	136	141	111	1.00	111	(90–132)
M RI	154	161	198	164	198	219	1.53	143	(124–162)
Middlbr	100	119	110	102	134	101	1.00	101	(81–120)
Newc	98	102	92	109	125	135	1.12	120	(100–141)
Norwch	88	75	78	77	112	97	0.79	123	(99–148)
Nottm	115	100	116	111	120	120	1.09	110	(91–130)
Oxford	176	170	164	188	195	218	1.69	129	(112–146)
Plymth	60	54	65	54	53	63	0.47	134	(101–167)
Ports	187	159	193	230	200	191	2.02	94	(81–108)
Prestn	138	146	154	164	163	133	1.49	89	(74–104)
Redng	103	72	117	104	87	96	0.91	105	(84–127)
Salford	131	134	116	161	173	188	1.49	126	(108–144)
Sheff	134	156	136	164	146	151	1.37	110	(93–128)
Shrew	61	58	60	65	62	58	0.50	116	(86–146)
Stevng	110	109	156	150	136	165	1.20	137	(116–158)
Sthend	29	26	42	30	35	47	0.32	148	(106–191)
Stoke	91	74	103	117	116	107	0.89	120	(97–143)
Sund	57	71	51	63	63	94	0.62	152	(121–183)
Truro	39	49	47	40	70	50	0.41	121	(87–155)
Wirral	58	46	65	55	64	69	0.57	121	(92–149)
Wolve	78	88	93	74	85	64	0.67	96	(72–119)

Kidney Failure Risk Equation

- [The Kidney Failure Risk Equation]

https://www.kidneyfailurerisk.co.uk/

KFRE

- KFRE is a well validated risk prediction tool, recommended by NICE, for the prediction of KRT in the next two or five years in individuals with CKD Stages 3a to 5.

- KFRE uses age, sex, eGFR and ACR to make a KRT prediction.

- KFRE is **not valid in individuals with rapidly changing kidney function** such as acute kidney injury, and should be used with caution in individuals with extreme body weights, amputations, urinary tract infection and bladder catheters.

- Consider referral to secondary care if a patient's KFRE five year risk is greater than 5%. This replaces the previous referral criteria of an eGFR <30 ml/min/1.73m^2

NICE referral criteria

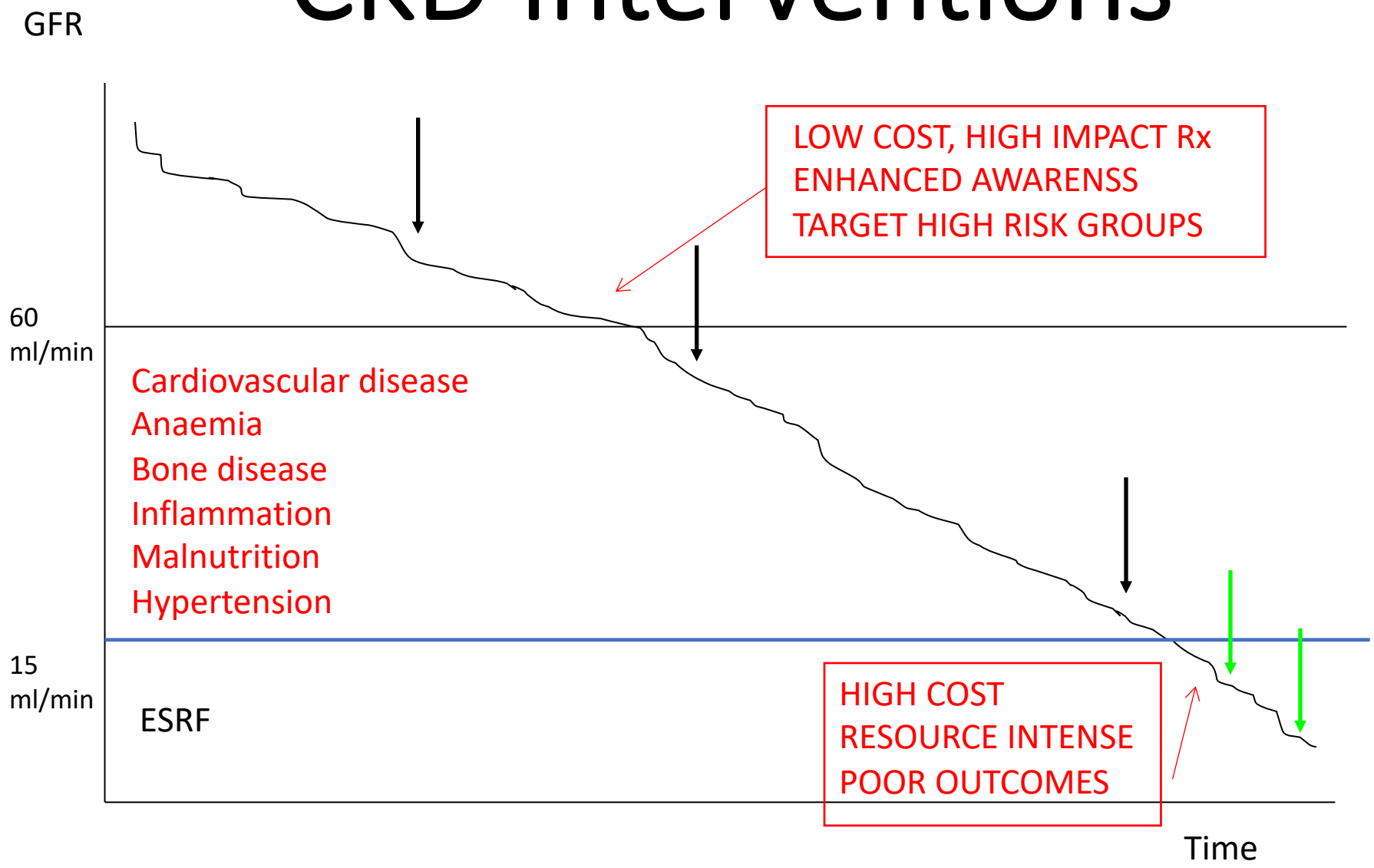
- Refer adults with CKD for specialist assessment (taking into account their wishes and comorbidities) if they have any of the following:
- a 5-year risk of needing renal replacement therapy of greater than 5% (measured using the 4-variable Kidney Failure Risk Equation)
- an ACR of 70 mg/mmol or more
- an ACR of more than 30 mg/mmol (ACR category A3), together with haematuria
- a sustained decrease in eGFR of 25% or more and a change in eGFR category within 12 months
- a sustained decrease in eGFR of 15 ml/min/1.73 m^2 or more per year
- hypertension that remains poorly controlled (above the person's individual target) despite the use of at least 4 antihypertensive medicines at therapeutic doses
- known or suspected rare or genetic causes of CKD
- suspected renal artery stenosis

Aims of CKD management

- Slow progression of CKD
- Exclude systemic disease

- General measures
  - BP control
  - Optimise Diabetes control
  - Review medications

CKD Interventions



MANAGEMENT OF INDIVIDUAL WITH DIABETIC NEPHROPATHY

Patient education is an integral part of overall management.

Lifestyle changes, weight loss and smoking cessation should be advised.

Target HbA1c:

Type 1 Diabetes

- CKD stages 1 and 2 = 48 - 58 mmol/mol.
- CKD stages 3 and 4 = 58 - 62 mmol/mol.
- CKD stage 5 (incl on dialysis) = 58 – 68 mmol/mol.

Type 2 Diabetes

- CKD stages 1 and 2 = 48 - 58 mmol/mol.
- CKD stages 3 and 4 on non-hypo inducing agents = 52 - 58 mmol/mol.
- CKD stages 3, 4 and 5 (incl on dialysis) on hypo inducing agents = 58 – 68 mmol/mo.l

Prescribe maximal tolerated dose of ACE Inhibitors or Angiotensin 2 receptor blockers

People with type 2 diabetes and albuminuria should be treated with SGLT2 inhibitor according to the individual drug licences, independently of glycaemic parameters. (Please see SGLT2I safe prescribing guidance slide 9).

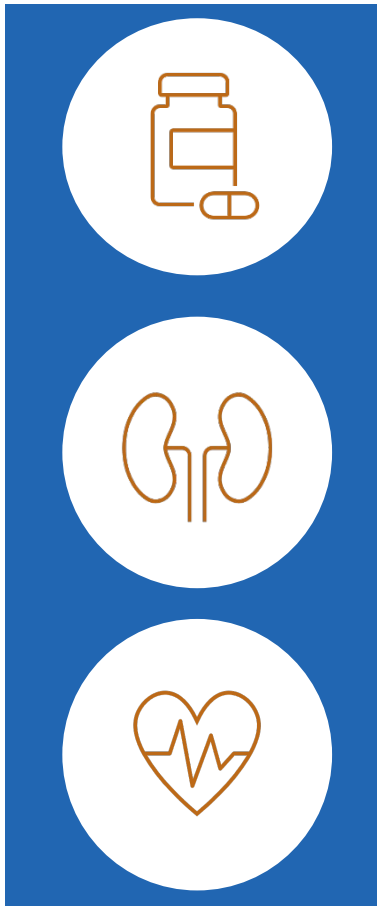
“3 within 3”

3 key actions within 3 months to save lives

LKN CKD Optimisation Pathway

In adults with Type 2 diabetes and CKD

(eGFR 25 - 75ml/minute/1.73m^2)



ACTION 1 (Month 1)
Maximum intensity RAS/ RAAS blockade

First, ensure the patient is on a statin, unless contraindicated.
Start ACE-inhibitor or ARB and titrate to maximum tolerated licensed dose *(NICE, NG203)* within one month

ACTION 2 (Month 2)
Initiate SGLT-2 inhibitor according to license

Consider/ counsel on risks of diabetic ketoacidosis (which may be euglycaemic), sick day rules, risk of UTI/fungal infections. Consider adjusting sulfonylureas/insulin where eGFR >45ml/min and HbA1c < 58mmol/mol to mitigate risk of hypoglycaemia.

ACTION 3 (Month 3)
Initiate further blood pressure agent to target 140/90mmHg unless uACR >70mg/mmol (then 120-129/80mmHg)

If BP remains above target initiate 2nd line BP agents as per NICE guidance (*NG203/ NG136)*

CHRONIC KIDNEY DISEASE Early diagnosis and management "3 within 3"

VERSION 8.2 Date of preparation: Mar 2023. For review: Nov 2023

Endorsed by CWHHE Diabetes Strategy Group

CKD IN PRIMARY CARE: NEW APPROACHES TO REDUCE INEQUALITIES AND SAVE LIVES
"3 in 3" early identification and optimization pathways

LKN London Kidney Network

The London Kidney Network are tasked by NHS England to work with ICSs across London to improve the care provided to people with kidney disease. A major part of their work stream relates to preventing progression of chronic kidney disease

A major initiative that has emerged by discussion and consultation across London's primary and secondary care networks has been the "3in3" initiative. This is aimed at ensuring we identify people with early kidney disease and rapidly optimise them to standards of care. If we can roll this out successfully many people will reap the benefits of better cardiovascular and kidney outcomes.

In adults with CKD be aware of these 3 TRIGGERS to start "3 within 3"

1. **Albuminuria (uACR ≥ 22.6mg/mmol)**
2. **Type 2 Diabetes**
3. **Heart failure**

3 key actions within 3 months to save lives
(optimization pathway) *detailed guidance next page

In adults with Type 2 diabetes and CKD
(uACR > 3mg/mmol or eGFR <60)

ACTION 1 (Month 1)
Maximum intensity RAS/ RAAS blockade

- ✓ First, ensure the patient is on a statin, unless contraindicated (e.g atorvastatin 40 mg OD up to 80mg to achieve target cholesterol)
- ✓ Start ACE-inhibitor or ARB and titrate to maximum tolerated licensed dose *(NICE, NG203)* within one month (see page 4)
- ⚠ Stop nephrotoxic medications : Advise against use of NSAID's and discuss alternatives. Advise on sick day rules

ACTION 2 (Month 2)
Initiate SGLT-2 inhibitor according to license

- ✓ Initiate SGLT2i according to license (see page 5)
- ⚠ Counsel patient on sick day rules, and the risk of UTI/fungal infection.
- ⚠ Consider/ counsel on risks of diabetic ketoacidosis (which may be euglycaemic),
- ⚠ Consider adjusting sulfonylureas/insulin where eGFR >45ml/min and HbA1c < 58mmol/mol to mitigate risk of hypoglycaemia.
- ✓ Refer to the patient information leaflet: Prescribing SGLT2in CKD and diabetes

ACTION 3 (Month 3)
Initiate further blood pressure agent to achieve BP target

Target: BP: 120-129/<80 mmHg

- ✓ Initiate further BP agent as per NICE guidance (*NG203/ NG136)*

In adults with albuminuria, without Type 2 diabetes
(uACR ≥ 22.6mg/mmol and eGFR 25 - 75ml/minute/1.73m²)

ACTION 1 (Month 1)
Maximum intensity RAS/ RAAS blockade

- ✓ First, ensure the patient is on a statin, unless contraindicated (e.g atorvastatin 40 mg OD up to 80mg to achieve target cholesterol)
- ✓ Start ACE-inhibitor or ARB and titrate to maximum tolerated licensed dose *(NICE, NG203)* within one month (see page 4)
- ⚠ Stop nephrotoxic medications : Advise against use of NSAID's and discuss alternatives. Advise on sick day rules

ACTION 2 (Month 2)
Initiate SGLT-2 inhibitor according to license

- ✓ Initiate SGLT2i according to license (see page 5)
- ⚠ Counsel patient on sick day rules, and the risk of UTI/fungal infection.
- ✓ Refer to the patient information leaflet : prescribing SGLT2i in CKD without diabetes

ACTION 3 (Month 3)
Initiate further blood pressure agent to achieve BP target

Target: If uACR <70mg/mmol BP: 120-139/<80mmHg
Target: If uACR >70 mg/mmol BP: 120-129/<80mmHg

- ✓ Initiate further BP agent as per NICE guidance (*NG203/ NG136)*

CHRONIC KIDNEY DISEASE RAAS up titration guidance

VERSION 8.2 Date of preparation: Mar 2023. For review: Nov 2023

Endorsed by CWHHE Diabetes Strategy Group

Benefits of ACEi and ARB use in CKD:

- ✓ Prevent scarring in CKD and should be used preferentially in patients with proteinuria.
- ✓ Offer cardiovascular protection

RAAS rapid up-titration algorithm

Confirm if the patient suitable for rapid RAAS up-titration

↓

Start ACEi or ARB if ACEi not tolerated at half max daily dose
(e.g. Ramipril 5mg OD or irbesartan 150mg OD)
Advise on sick day rules
Advise patient to maintain good fluid input 1-2L/day depending on size

↓

Check Creatinine and potassium 1 to 2 weeks after initiation *

↓

Review blood results and blood pressure. If appropriate continue dose increment

↓

Increase ACEi/ ARB dose to maximum tolerated (e.g. Ramipril 10mg OD or Irbesartan 150 BD)

↓

Check Creatinine and potassium 1 to 2 weeks after dose increase *

↓

Review blood results and blood pressure. If appropriate continue max dose

Which patients should avoid rapid RAAS up-titration

In patients with low baseline blood pressure

Patients with significant comorbidities

Consider reducing other BP agents
Use individualised BP targets when significant frailty (page 11)
Attempt slower RAAS up-titration

Blood results monitoring

Creatinine and eGFR

Accept a serum creatinine rise up to 30% or eGFR fall of 25%: after ACEi/ARB initiation or dose increase

If renal function deterioration greater than stated above seek nephrologist advice (to exclude possible renovascular disease) ICHC-tr.ckdadvice@nhs.net, and

STOP ACEi/ARB if no other causes of deteriorating renal function (e.g. dehydration, use of NSAIDs) is found

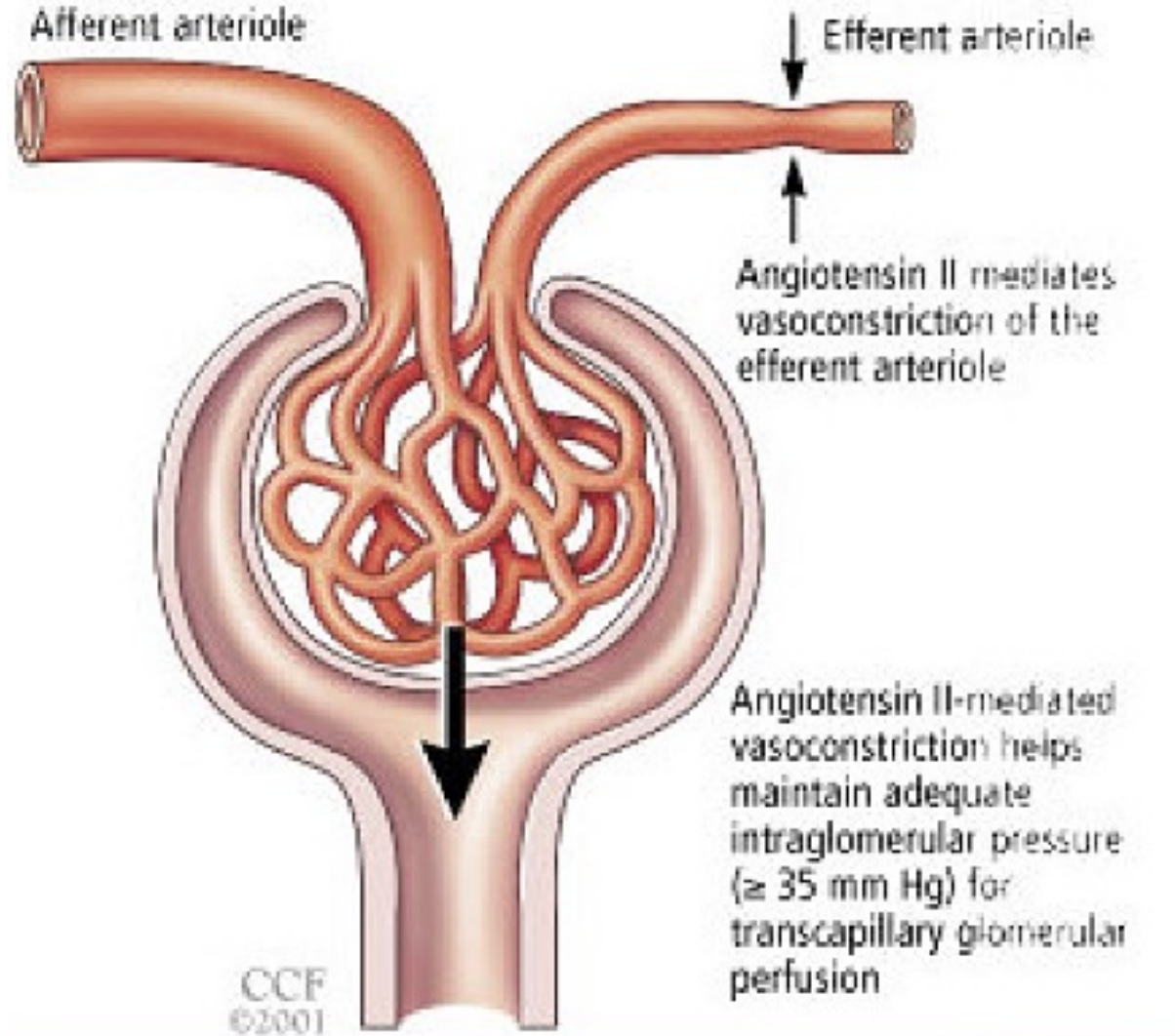
Potassium (K+)

If K>6.0 stop ACEi/ARB and start low potassium diet

if the patient has proteinuria or heart failure with reduced ejection fraction and would benefit from an ACEi/ARB seek nephrologist advice as introduction of potassium binders, furosemide or bicarbonate can facilitate reintroduction of these agents.

Concomitant use of ACEi/ARB with spironolactone and other potassium sparing diuretics requires close monitoring of potassium

The role of angiotensin II in maintaining adequate intraglomerular pressure



ORIGINAL ARTICLE

Dapagliflozin in Patients with Chronic Kidney Disease

Hiddo J.L. Heerspink, Ph.D., Bergur V. Stefánsson, M.D., Ricardo Correa-Rotter, M.D., Glenn M. Chertow, M.D., Tom Greene, Ph.D., Fan-Fan Hou, M.D., Johannes F.E. Mann, M.D., John J.V. McMurray, M.D., Magnus Lindberg, M.Sc., Peter Rossing, M.D., C. David Sjöström, M.D., Roberto D. Toto, M.D., Anna-Maria Langkilde, M.D., and David C. Wheeler, M.D., for the DAPA-CKD Trial Committees and Investigators*

ABSTRACT

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JUNE 13, 2019 VOL. 380 NO. 24

Canagliflozin and Renal Outcomes in Type 2 Diabetes and Nephropathy

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Empagliflozin in Patients with Chronic Kidney Disease

The EMPA-KIDNEY Collaborative Group*

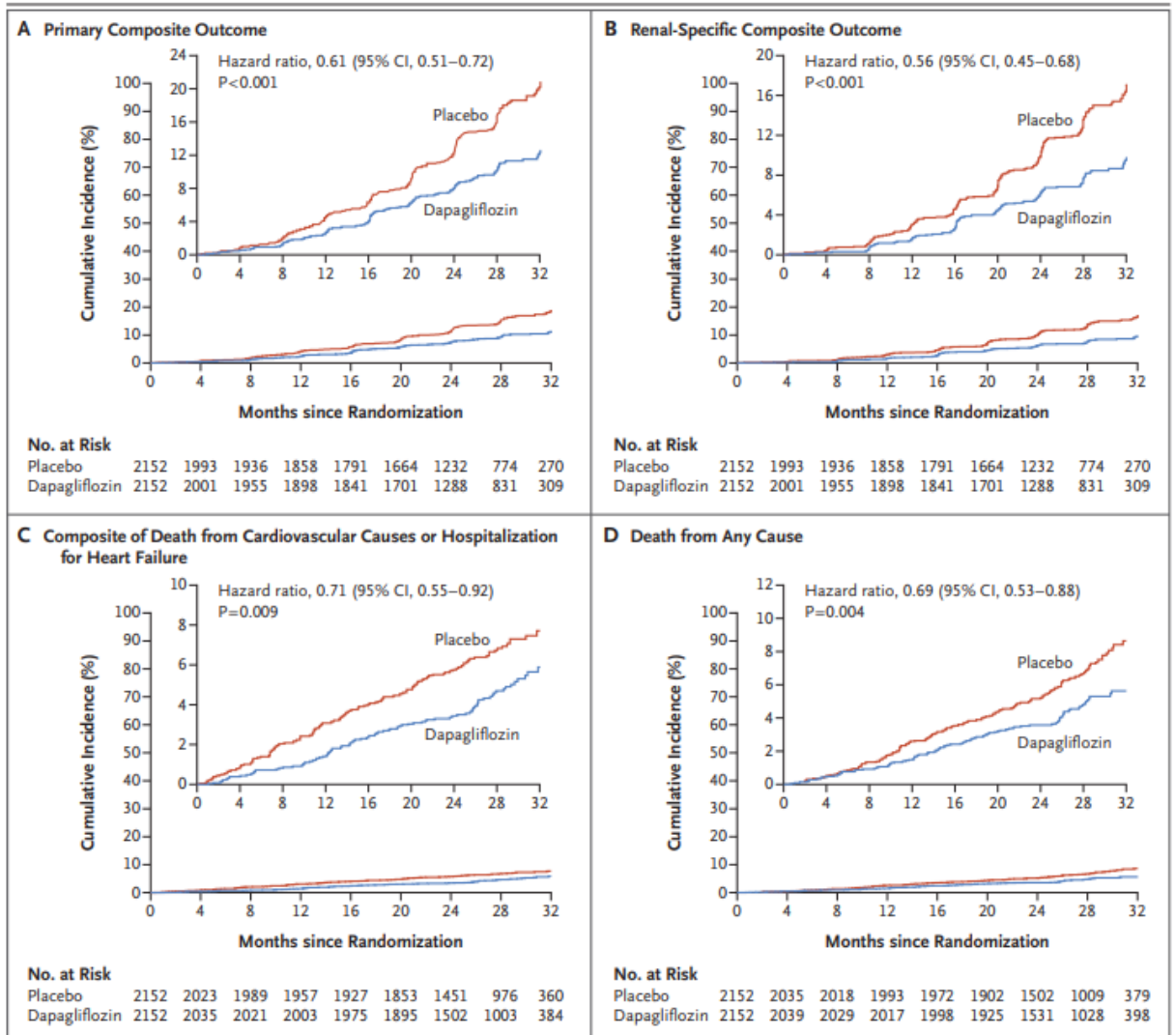
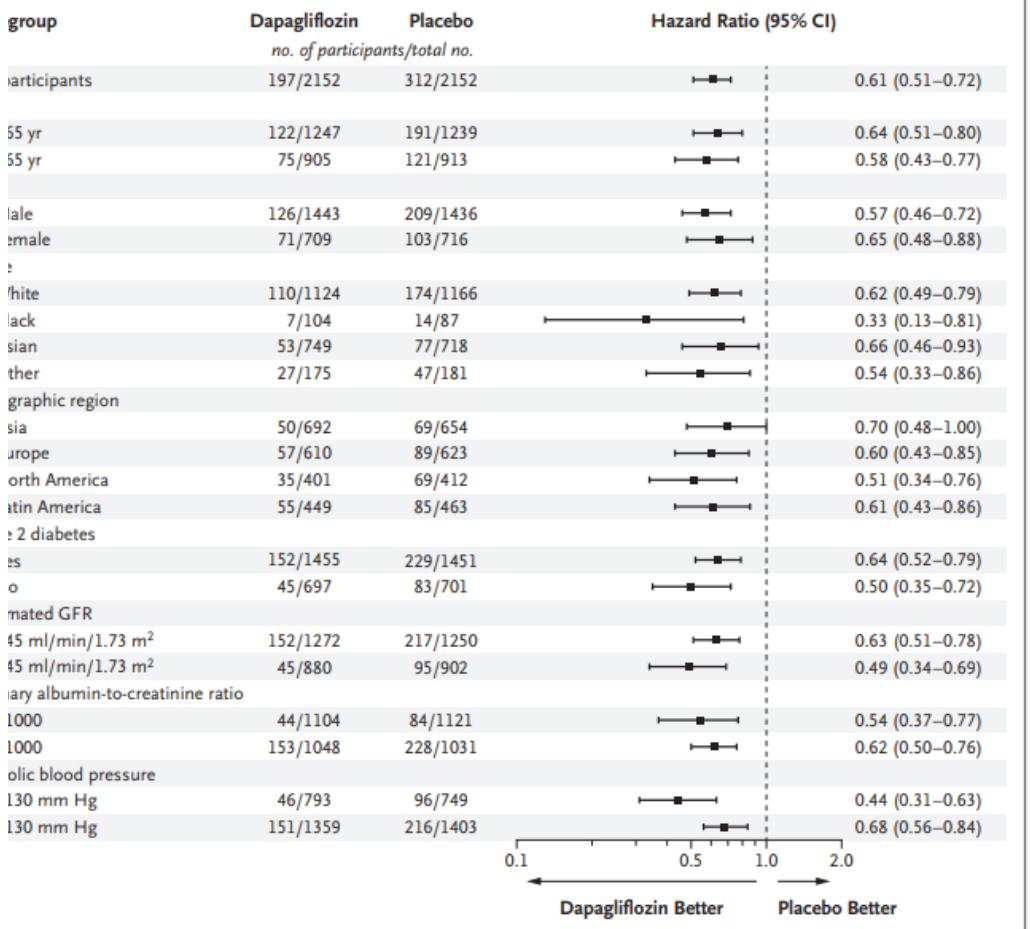


Figure 1. Primary and Secondary Outcomes.

The primary outcome was a composite of a sustained decline in the estimated glomerular filtration rate (GFR) of at least 50%, end-stage kidney disease, or death from renal or cardiovascular causes (Panel A). The primary outcome and the secondary outcomes of a composite of a sustained decline in the estimated GFR of at least 50%, end-stage kidney disease, or death from renal causes (Panel B), a composite of death from cardiovascular causes or hospitalization for heart failure (Panel C), and death from any cause (Panel D) were estimated with the use of the Kaplan–Meier method. Hazard ratios, confidence intervals, and P values were estimated with the use of Cox proportional-hazards regression models, stratified according to randomization factors (diabetes diagnosis and urinary albumin-to-creatinine ratio) and adjusted for baseline estimated GFR. Included in these analyses are all the participants who had undergone randomization and received at least one dose of dapagliflozin or placebo. The graphs are truncated at 32 months (the point at which <15% of participants remained at risk). The insets show the same data on an expanded y axis.



re 2. Primary Outcome According to Prespecified Subgroups at Baseline.

wn are forest plots of the hazard ratios for the primary outcome (a composite of a sustained decline in the esti-ed GFR of ≥50%, end-stage kidney disease, or death from renal or cardiovascular causes) according to prespeci-baseline subgroups. Hazard ratios and confidence intervals were calculated with a Cox proportional-hazards el with stratification according to diabetes status and urinary albumin-to-creatinine ratio adjusted for baseline nated GFR, with factors for trial group, subgroup, and the interaction between trial group and the subgroup ible. Race was reported by the investigators. The albumin-to-creatinine ratio was calculated with albumin mea-d in milligrams and creatinine measured in grams.

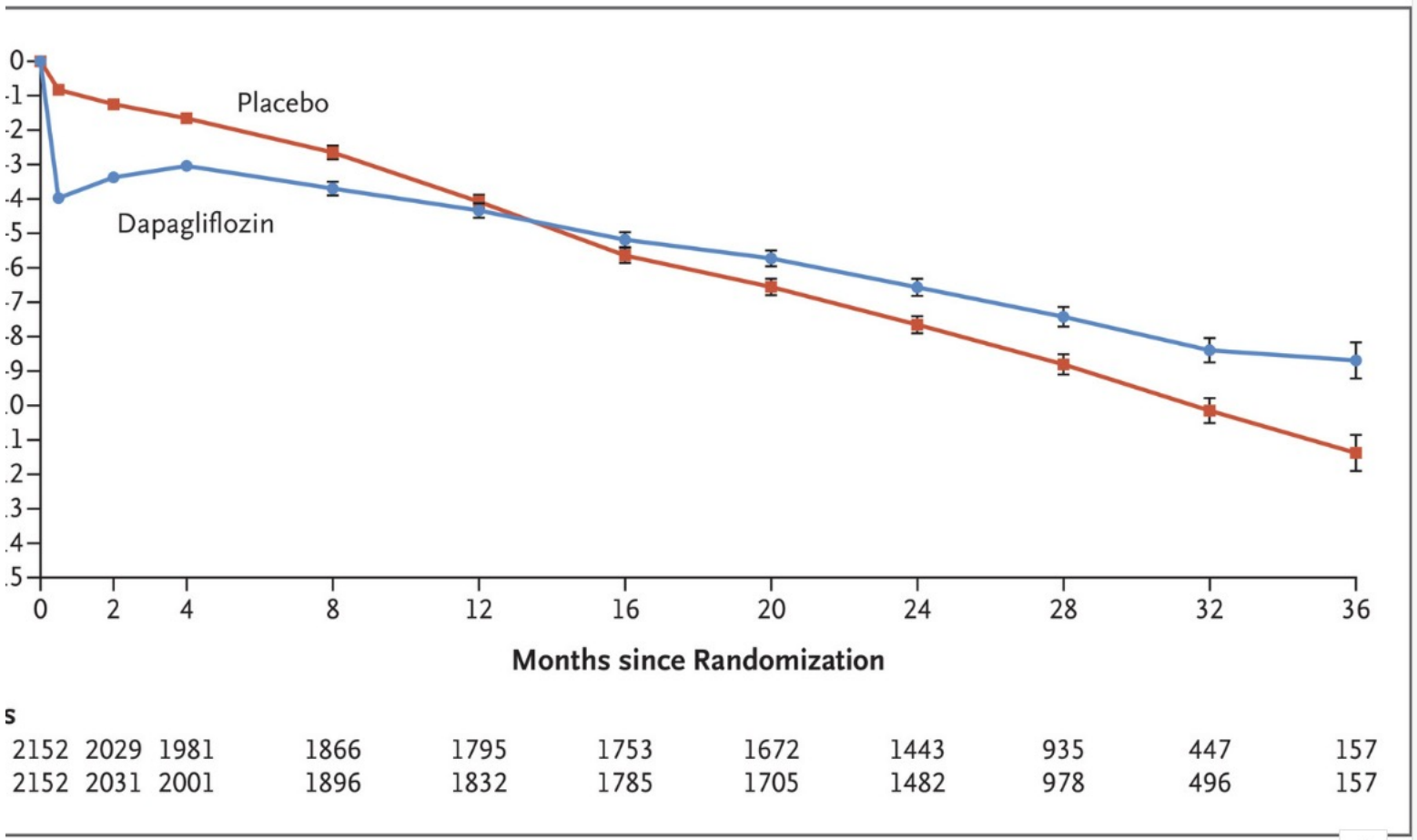
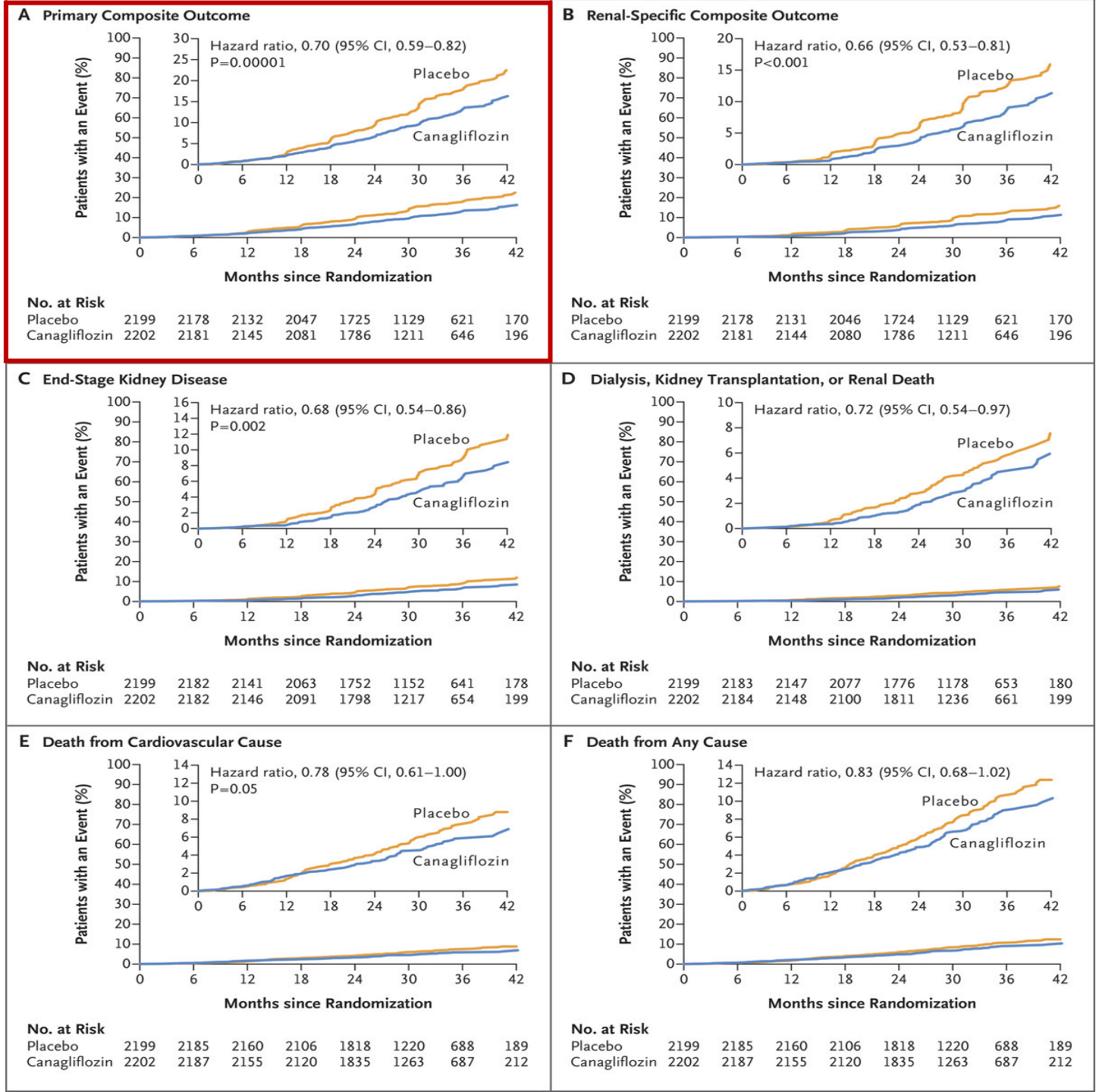
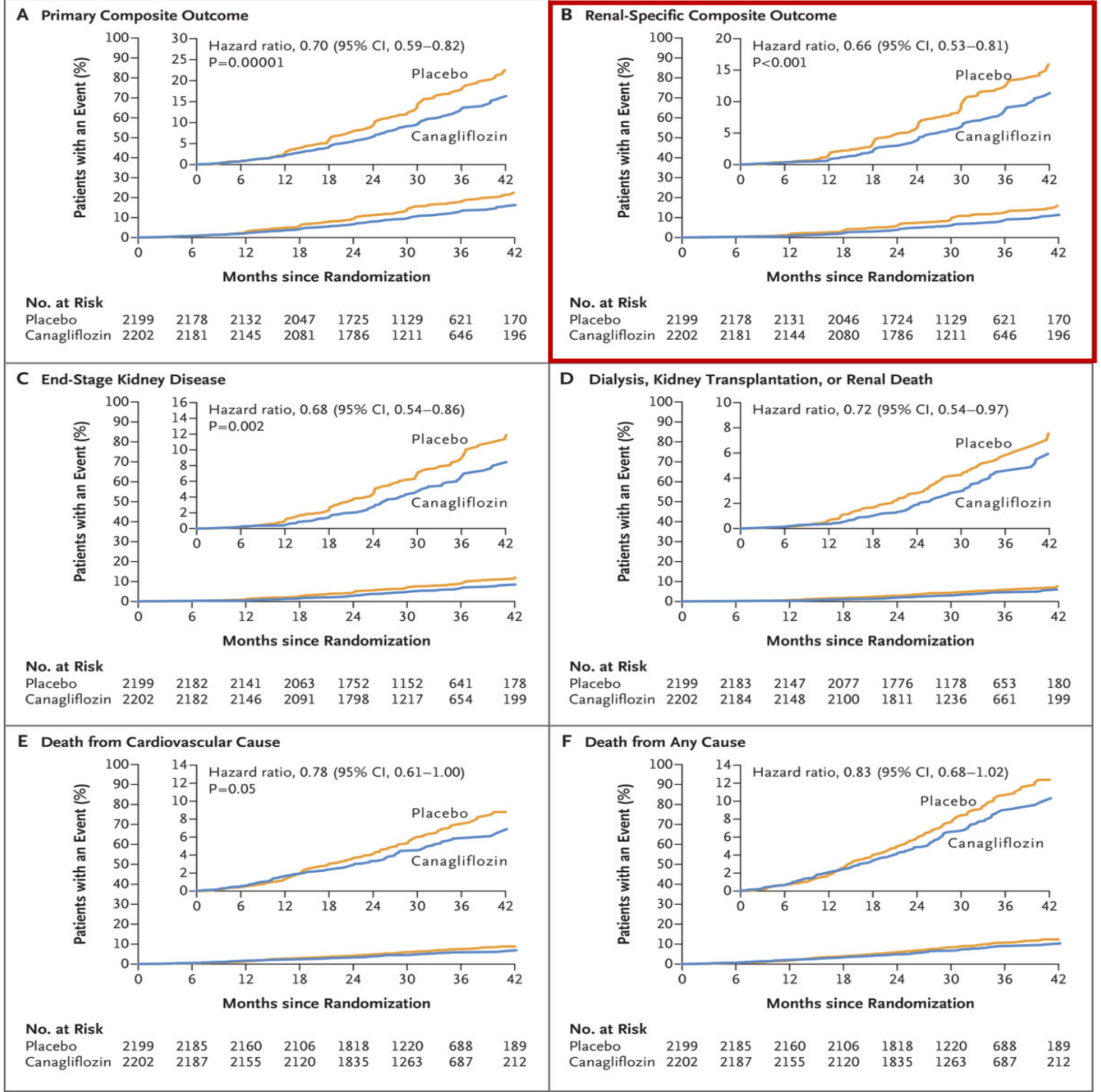


Figure 3. Change from Baseline in Estimated GFR.

Shown is the least-squares mean change from baseline in the estimated GFR, calculated with the use of a repeated-measures analysis including terms for trial group, baseline measurement, visit, and interaction between visit and trial group. The I bars indicate standard errors. The mean estimated GFR at baseline was 43.2 ml per minute per 1.73 m^2 of body-surface area in the dapagliflozin group and 43.0 ml per minute per 1.73 m^2 in the placebo group.



V Perkovic et al. N Engl J Med 2019;380:2295-2306.



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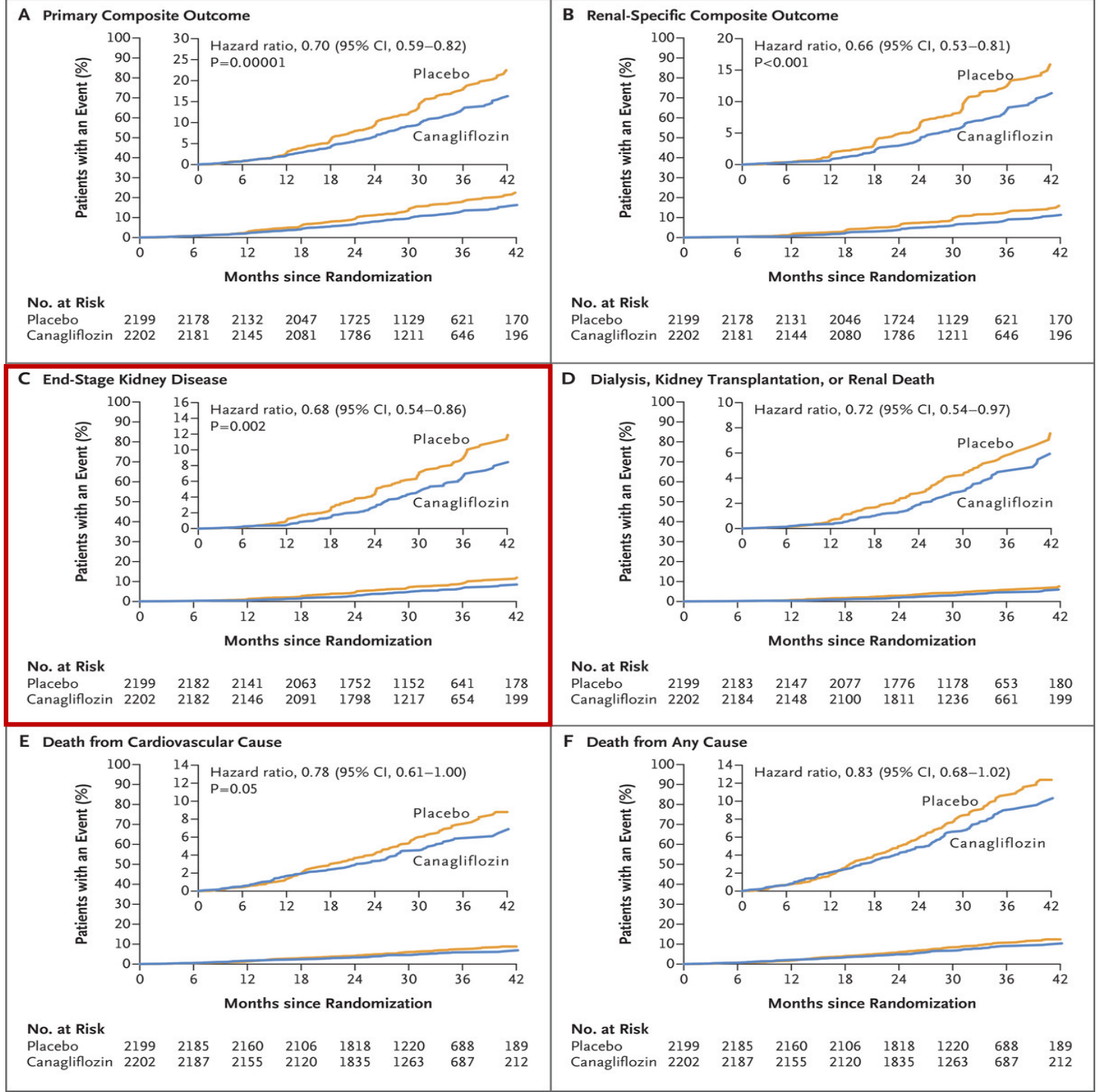

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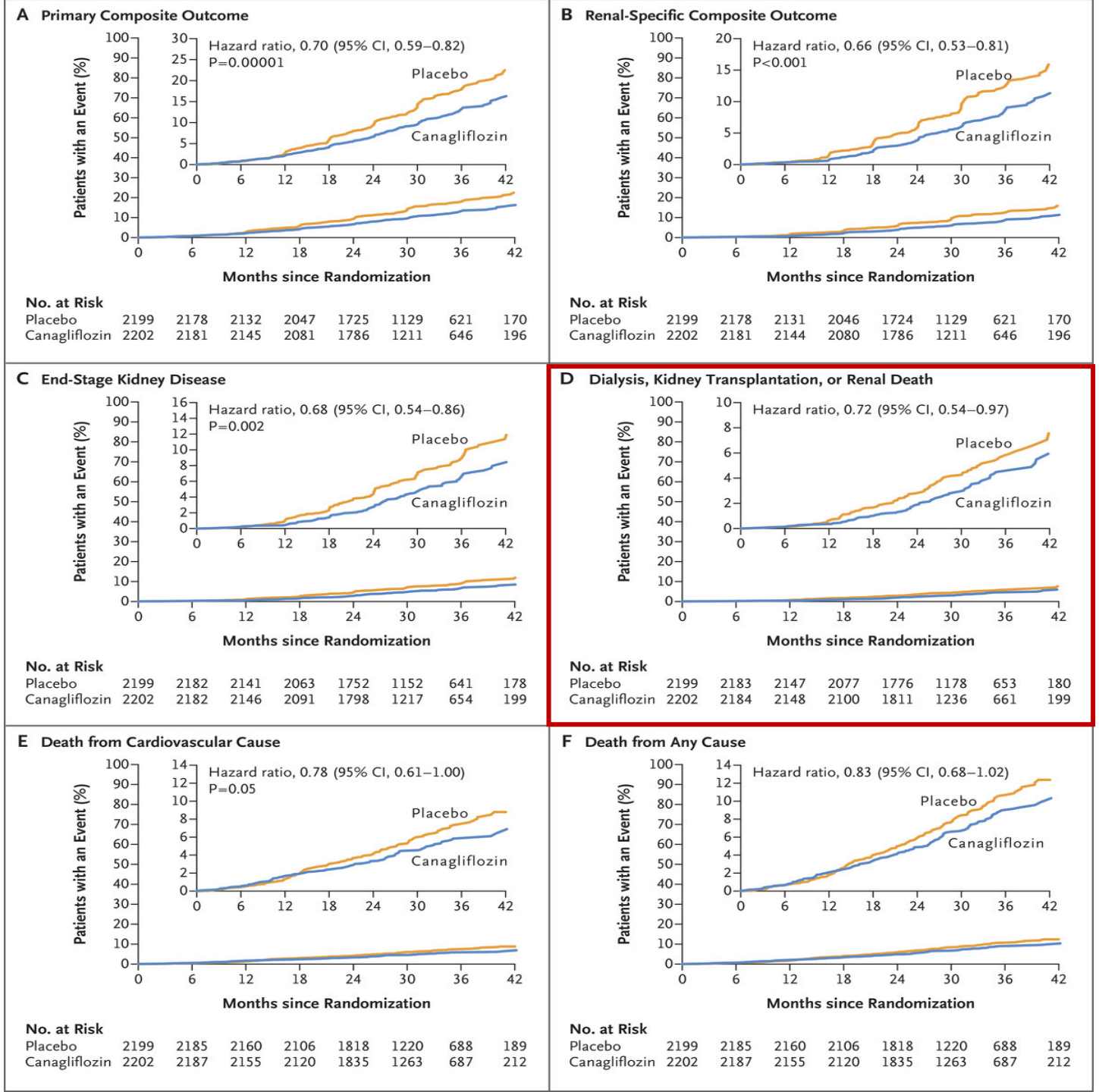
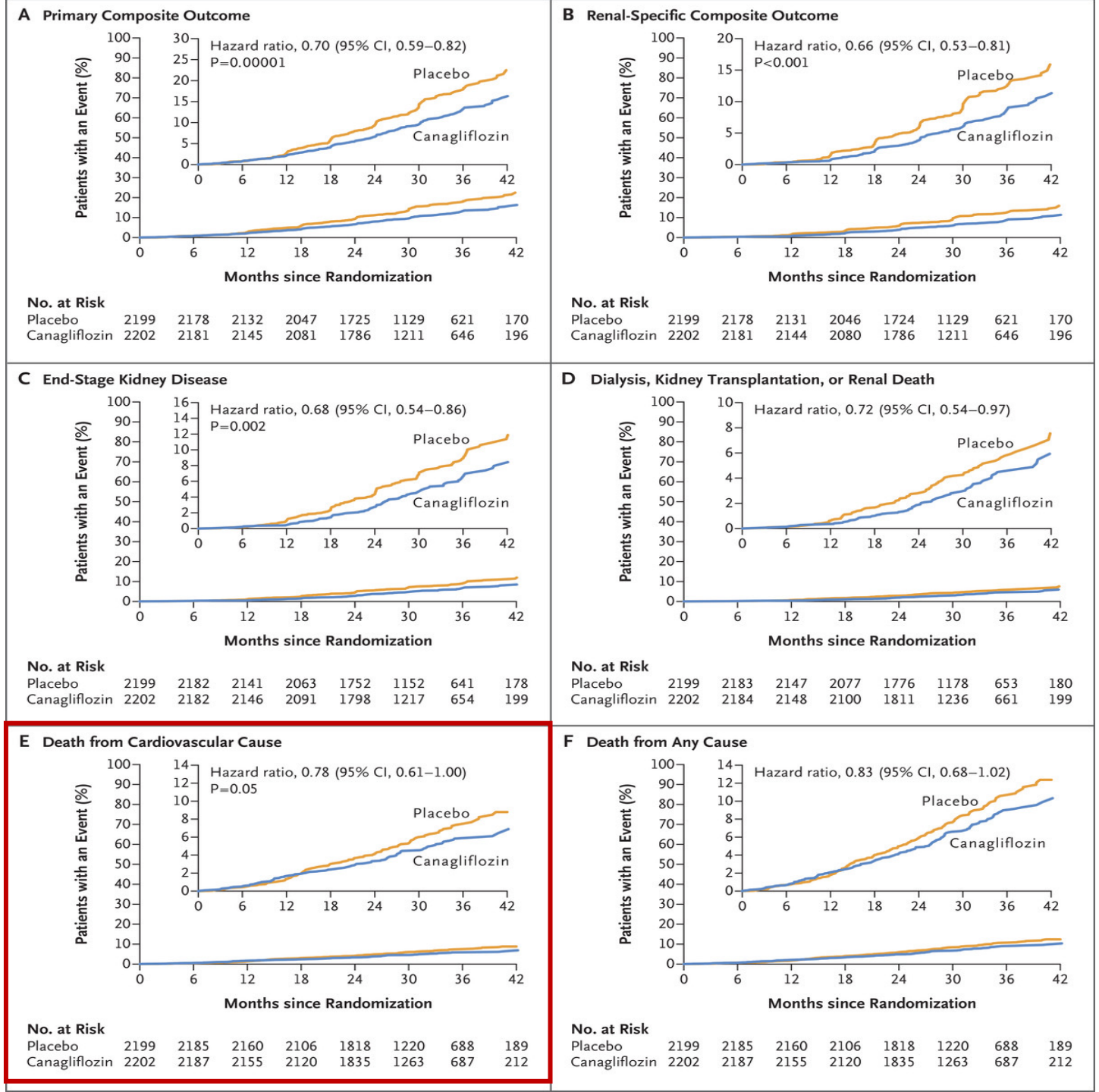


V Perkovic et al. N Engl J Med 2019;380:2295-2306.



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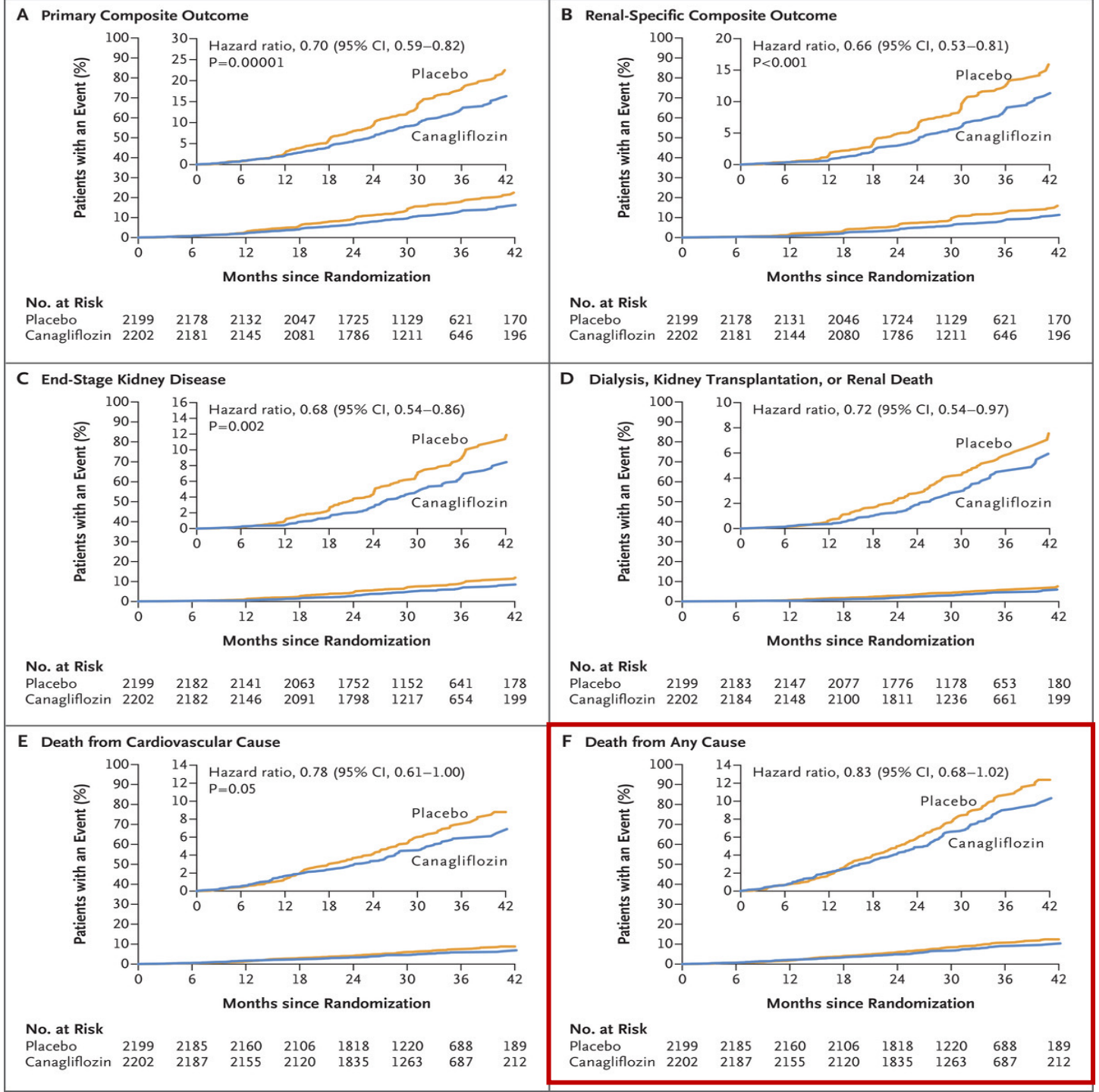


V Perkovic et al. N Engl J Med 2019;380:2295-2306.

CHRONIC KIDNEY DISEASE – SGLT2 inhibitors prescribing guidance

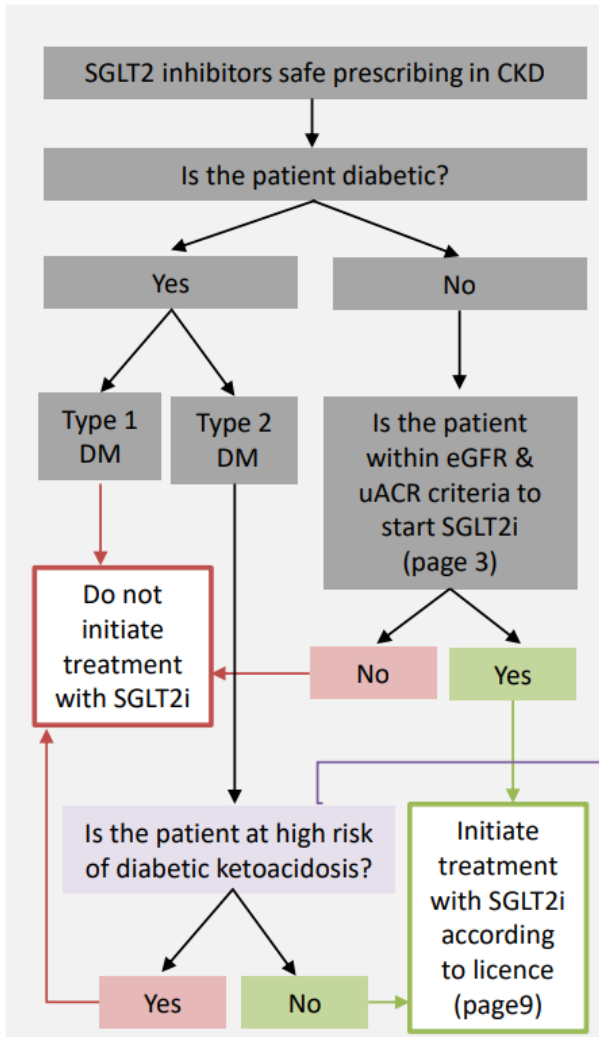
VERSION 8.2 Date of preparation: Mar 2023. For review: Nov 2023

Endorsed by CWHHE Diabetes Strategy Group

Chronic Kidney Disease and SGLT2 inhibitors: safe prescribing guidance

Benefits of SGLT2i in CKD

- ✓ cardio renal protective effects over and above their glycaemic effectiveness
- ✓ Also refer to each individual drug's current licence (see slide 9).



CAUTIONS WHEN PRESCRIBING SGLT2I

- Frail elderly
- Potential for pregnancy
- Always offer advice on *sick day guidance* when introducing these agents and reiterate at every opportunity i.e. stop perioperatively or if restricted food intake or dehydration.
- Reiterate that if on an SGLT2I, very low carbohydrate diets (or ketogenic diets) carry an increased risk of ketosis.
- In people with reasonable glycaemic control, preserved renal function (eGFR >45), consider reducing other insulin or sulfonylureas when introducing SGLT2I.
- In people on diuretics, consider reducing the dose.
- Give advice to seek medical attention (via GP, urgent care centre or pharmacy) should they develop symptoms of a genital infection.
- Caution is advised if the person has active peripheral vascular disease including active arterial ulceration or claudication.

INCREASED RISK OF EUGLYCAEMIC DIABETIC KETOSIS

- Those who rapidly progressed to requiring insulin (within 1 year of diagnosis).
- Past history of diabetic ketoacidosis (DKA).
- History of pancreatic disease – including alcoholic pancreatitis as a cause of their pancreatitis.
- BMI < 27.
- The possibility of Latent Autoimmune Diabetes in Adults.

✓ Initiate

✓ No new initiation; continue at stated dose

✖ Discontinue

CHRONIC KIDNEY DISEASE – Type 2 diabetes and SLGT2i prescribing

VERSION 8.2 Date of preparation: Mar 2023. For review: Nov 2023

Endorsed by CWHHE Diabetes Strategy Group

TYPE 2 DIABETES AND CHRONIC KIDNEY DISEASE: SAFE PRESCRIBING GUIDANCE

Drug	**CKD stage 1** eGFR >90 mL/min	**CKD stage 2** eGFR 60-90 mL/min	**CKD stage 3a** eGFR 45-59 mL/min	**CKD stage 3b** eGFR 30-44 mL/min	**CKD stage 4** eGFR 15-29 mL/min	**CKD stage 5** eGFR <15 mL/min	**Mild to moderate hepatic impairment**	**Severe hepatic impairment**	CKD without DM
Metformin	✓	✓	✓	✓ Max 500mg BD	✖	✖	Specialist initiation only	✖	✖
Gliclazide	✓	✓	✓	✓	Use lowest effective dose	✖	✓	✖	✖
Linagliptin	✓	✓	✓	✓	✓	✓	✓	✓	✖
Sitagliptin	100 mg	100 mg	100mg	50mg	25mg	25mg	✓	✖	✖
Alogliptin	25mg	25mg	25mg	12.5mg	6.25mg	6.25mg	✓	✖	✖
Pioglitazone (TZD)	✓	✓	✓	✓	✓	✓	✖	✖	✖
Dapagliflozin	✓ Start 10mg	✓ Start 10mg	✓ Start 10mg	✓ (*) Start 10mg	✓ (*) Start 10mg	✓ (*) Continue 10mg (✖ on dialysis)	✓	✓ 5mg	✓ Start 10mg (uACR >22)
Canagliflozin	✓ Start 100-300mg	✓ Start 100-300mg	✓ Start 100mg	✓ (*) Start 100mg, only if uACR >30mg/mmol	✓ (*) Continue 100mg if uACR >30mg/mmol	✓ (*) Continue 100mg if uACR >30mg/mmol (✖ on dialysis)	✓	✖	✖
Empagliflozin	✓ Start 10-25mg	✓ Start 10-25mg	T2DM Continue 10mg T2DM + HFrEF ✓ Start 10mg	T2DM only ✖ T2DM + HFrEF ✓ Start 10mg (*)	T2DM only ✖ T2DM + HFrEF & eGFR <20 ✖ T2DM + HFrEF + eGFR >20 ✓ Start 10mg (*)	✖	✓	✖	✖
Ertugliflozin	✓ Start 5-15mg	✓ Start 5-15mg	✓ Continue 5-15mg	✖	✖	✖	✓	✖	✖
Liraglutide	✓	✓	✓	✓	✓	✖	✓	✖	✖
Semaglutide	✓	✓	✓	✓	✓	✖	✓	Caution: limited information	✖
Dulaglutide	✓	✓	✓	✓	✓	✖	✓	✓	✖
Insulin	✓	✓	✓	✓	✓	✓	✓	✓	✖

(*)Be Aware: **Diminished glycaemic effect of SGLT-2i with eGFR < 45 mL/min, however sustained cardio-renal protection**

NICE

Finerenone for treating chronic kidney disease in type 2 diabetes

Technology appraisal guidance
Published: 23 March 2023

www.nice.org.uk/guidance/ta877

1) Criteria for treatment (All to be fulfilled)
i. Type 2 Diabetes and
ii. CKD eGFR between 25 and 60
iii. On both maximal tolerated ACEi/ARB and SGLT2i unless the patient has a documented intolerance to 1 of these groups of drugs and
iv. Residual albuminuria (ACR > 3) and
v. Potassium less than 5.0
i. Does not have an indication for spironolactone based on heart failure guidance

Open access Research

BMJ Open

Predictors of late presentation to renal dialysis: a cohort study of linked primary and secondary care records in East London

Ademola Olaitan,[1] Neil Ashman,[1] Kate Homer,[2] Sally Hull[2]

ABSTRACT

Objectives The outcomes and experience of care for patients who start renal replacement therapy (RRT) in an unplanned manner are worse than for those who have planned care. The objective of this study was to examine the primary care predictors of unplanned starts to RRT.

Design Retrospective cohort study with linked primary care and hospital data.

Setting 128 general practices in East London with a combined population of 1 043 346 people.

Participants 999 consecutive patients starting dialysis at Barts Health National Health Service Trust between September 2014 and August 2017.

Primary outcome measures Unplanned versus a planned start to dialysis among the cohort of 389 patients with a linked primary care record. An unplanned start to dialysis is defined as receiving nephrology care in the low clearance clinic (or equivalent) for less than 90 days. A planned start is defined as access to pre-dialysis counselling and care for at least 90 days prior to commencing dialysis.

Results The adjusted logistic regression analysis showed that the most important modifiable risk factors for unplanned dialysis were the absence of a chronic kidney disease (CKD) code in the general practice (GP) record (OR 8.02, 95% CI 3.65 to 17.63) and the absence of prescribed lipid lowering medication (OR 2.37, 95% CI 1.05 to 5.34). Other contributing factors included male gender and a greater number of long-term conditions.

Conclusions Improving CKD coding in primary care and the additional review and clinical scrutiny associated with this may contribute to a further reduction in unplanned RRT rates.

Coding in Practice

A patient with known type 2 diabetes and hypertension has routine blood and urine tests. The results are shown and highlighted below in yellow. Their eGFR is 74ml/min and the ACR is 5.5mg/mmol.

eGFR value (ml/min)	Possible Code Group 1	Possible Code Group 2
Greater than 90	G1	CKD stage 1
60-90	G2	CKD stage 2
45-59	G3a	CKD stage 3
30-44	G3b	CKD stage 3
15-29	G4	CKD stage 4
Less than 15	G5	CKD stage 5

ACR value (mg/mmol)	Possible Code Group 1	Possible Code Group 2
0-3	A1	No code
3-30	A2	Microalbuminuria
Greater than 30	A3	Albuminuria

Using the coding tables above, possible coding would be:

If using Group 1- **CKD G2A2**

If using Group 2- **CKD2, Microalbuminuria**

Coding Recommendations

Use Group 1

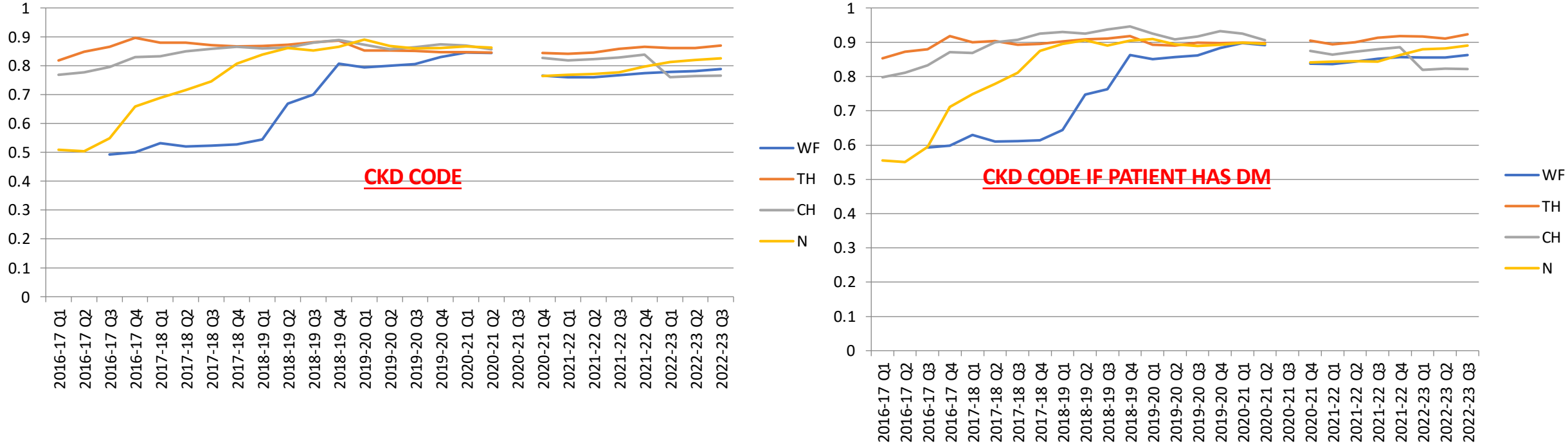
- Provides the most granularity. Coding is precise and follows the KDIGO guidance and NICE recommendations.
- Requires a single SNOMED code
- Aligns more readily to recommendations around frequency of testing
- Allows for easier tracking of disease progression
- Requires some working knowledge of CKD due to increased granularity
- May require more frequent updates as and when disease progresses
- Some coding is not defined and eligible under QOF business rules e.g. A2

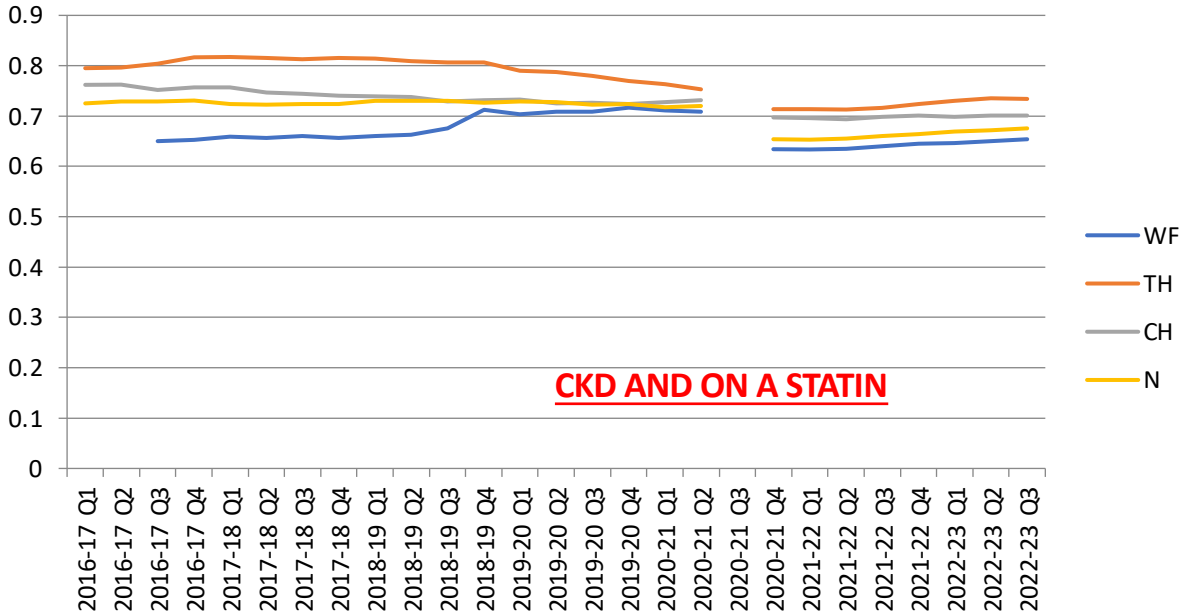
Guide to Frequency of Monitoring (number of times per year) by GFR and Albuminuria Category

GFR categories (ml/min/1.73 m²) Description and range				Persistent albuminuria categories Description and range		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30–300 mg/g 3–30 mg/mmol	>300 mg/g >30mg/mmol
	G1	Normal or high	≥90	1 if CKD	1	2
	G2	Mildly decreased	60–89	1 if CKD	1	2
	G3a	Mildly to moderately decreased	45–59	1	2	3
	G3b	Moderately to severely decreased	30–44	2	3	3
	G4	Severely decreased	15–29	3	3	4+
	G5	Kidney failure	<15	4+	4+	4+

CKD coding

The adjusted logistic regression analysis showed that the most important modifiable risk factors for unplanned dialysis were the absence of a chronic kidney disease (CKD) code in the general practice (GP) record (OR 8.02, 95% CI 3.65 to 17.63) Olaitan et al BMJ Open 2019

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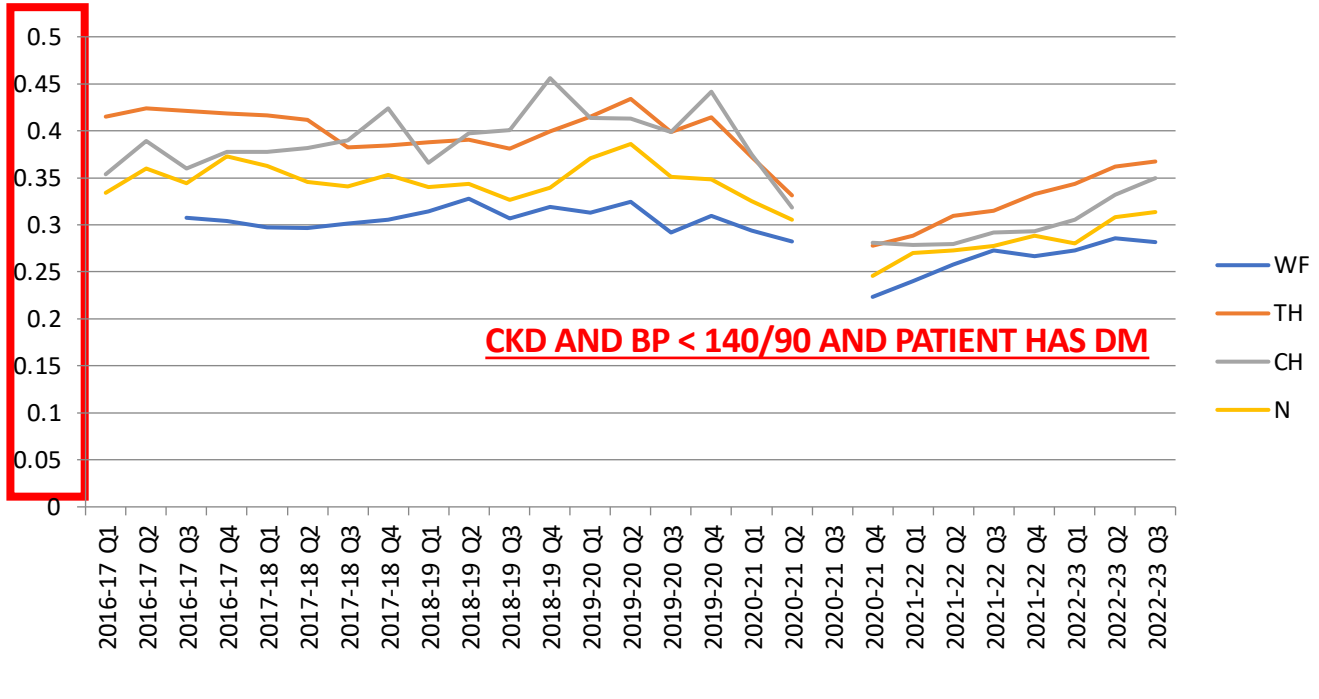
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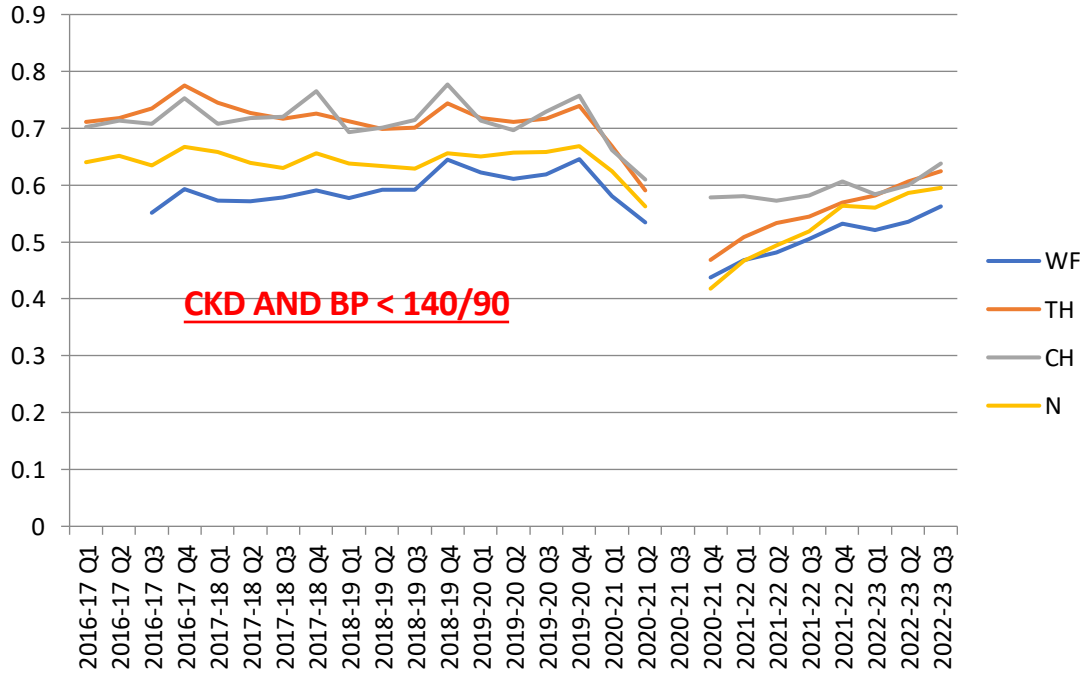
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Who to refer

- Sustained decrease in GFR of ≥ 25% and/or ≥ 15ml/min within 12 months

URGENT REFERRAL

- Suspected multisystem disease with evidence of renal involvement
- Acute kidney injury (without an obvious cause manageable in primary care)
- Newly diagnosed eGFR < 15
- Nephrotic syndrome or heavily proteinuric
- Accelerated hypertension

Useful Resources

- None (nwlondonicb.nhs.uk)

  https://www.nwlondonicb.nhs.uk/professionals/referral-guidelines-and-clinical-documents/chronic-kidney-disease – summary of NICE guidelines in easy to follow format with practical tips

- Overview | Chronic kidney disease: assessment and management | Guidance | NICE

Summary

- Definition
- Risk stratification
  - Importance of urine dip
- Aims of Management
- Resources
- Questions

Newham Protected Learning Time Agenda

Thursday 6th July 2023, 14:30 – 17:30

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	Agenda Items	Lead	Times
1	Spinal Pathways • *Referral pathway to spine* • *What to refer to the spine service* • *Cauda Equina and MSCC pathway*	**Phil Barber** - Advanced Physiotherapy Practitioner & Clinical Pathways Lead (NE London and Essex Spinal Network)	14:30 – 15:00
2	MSK Self-Management App	**getUbetter Team**	15:00 – 15:15
3	Break		15:15 – 15:20
4	Cancer • *Update on new urgent suspected cancer referral forms* • *PSA reference changes and Colon Flag* • *Early Diagnosis DES: learning so far and next steps* • *Non-site specific cancer pathway* • *CEG resources* • *Quality issues and service alerts*	**Dr Helen Stedeford** - Newham Clinical Lead Cancer	15:20 – 16:20
5	Break		16:20 – 16:30
6	CKD • *Management of CKD - "3 within 3"* • *New therapies for CKD* • *Useful resources for CKD management*	**Ademola Olaitan -** vCKD Newham	16:30 – 17:30

Newham Protected Learning Time Your Feedback!

https://www.surveymonkey.co.uk/r/PLT_July23

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