



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

**MSc Public Health and Social Care in
Practice**

**Community Care and Management of
Long-Term Conditions**

LCHS7003

**Information Booklet of Long-Term
Conditions Management**

Topic: Chronic kidney disease

Lecturer Name: Dr Brian Mashumba

Student Name: Ronak Yusuf sheikh

Student Id: 2436884

Table of Contents

1. Introduction	2
2. Overview of CKD in the United Kingdom	3
3. Risk factor and aetiology.....	2
4. Theoretical perspectives and models	6
5. Policy and political context.....	8
6. Recommendation for practise.....	10
7. Conclusion.....	11
8. References.....	12

INTRODUCTION

- Chronic kidney disease (CKD) is a long-term condition that causes the kidney to lose their ability to function properly overtime. It develops gradually, often over months or years and unfortunately cannot be reversed. Chronic kidney disease (CKD) is a serious global health concerns, affecting about one in ten adults world-wide.
- In the United Kingdom alone and around 3 million people are estimated to be living with this disease. Many people are suffering without knowing that they have diagnosed with the disease (Public Health England 2022) chronic kidney disease (CKD) which also inclines the chances of developing heart problems, needing hospital care and facing a shorter life expectancy.
- It also takes a heavy toll on people's quality of life, work productivity and the health care system. Chronic kidney disease often develops because of other conditions such as diabetes, high blood pressure, inflammation of the kidneys, disease like many long-term illnesses it needs a well-

rounded approach.

- That focuses on prevention, early diagnosis, better treatments and an active involvement from patient in managing their health. Chronic kidney disease (CKD) remains growing challenge for the NHS, demanding care that is both compassionate and coordinated.
- The national institute for health and care excellence (NICE) set out a clear direction through its 2021 NG203 guidelines, calling for care that focuses on the individuals, supports healthy lifestyle, and brings professionalism from multiple disciplines together.
- Building on this, the NHS long term plan (2019) emphasizes the value of prevention, early diagnosis and fair access to high quality renal services.

Overview of CKD in the United Kingdom

- **Definition and classification:**
- According to worldwide and UK guidelines; the classification of CKD as follows:

Stage	eGFR (mL/min/ 1.73m ²)	Albuminuria (ACR)
-------	---------------------------------------	----------------------

G1	≥90	A1 (normal–
G2	60–89	A1
G3A	45–59	A1-A3
G3B	30–44	A2-A3
G4	15-29	A2-A3
G5	< 15 or on	

chronic kidney disease (CKD) is generally defined as abnormalities in kidney structure and functions that are prevalent for more than three months and have health implications.

- The estimated Glomerular filtration rate (eGFR) and albuminuria, which is measured by the urine albumin to creatinine ratio, these the two most significant metrics utilised in categorization eGFR staged from G1 to G5 and gives measurement of renal filtration capacity A1 (normal to mildly raised), A2 (moderately increased), and A3 (severely increased). These are the three categories of Albuminuria.
- Both dimensions are used in clinical risk and management decisions because they are independently predict cardiovascular outcomes and progression. it is also crucial to confirm the

chronicity (abnormality present for at least three months) of the Kidneys.

- **CKD Staging (eGFR and albuminuria categories):**

- **Burden and prevalence:**

- In the UK prevalence has been increasing, partly because of aging population and rising rates of diabetes and hypertension. According to Public Health England (2022), roughly one in six years, adults shows some level of kidney impairment, although many remain undiagnosed.
- The impact of CKD is not evenly felt, rates are higher in more deprived areas and among ethnic minority groups, especially within people of colour and South Asian communities. Factors such as income, access to medical care, and health awareness play a major role in shaping these disparities.
- Recognising the scale of the problems, the NHS Long Term Plan (2019) has identified CKD as a key target for prevention and early management in primary care. Lot of people find out they have kidney issue when they end up in the hospital with serious complications. To change this, we

need to have earlier detection through regular screening for those at higher risk by improving communication and data sharing across healthcare services. Sharing information will educate people to be more aware of their Kidney health.

Risk factor and aetiology

- Chronic kidney disease (CKD) most often arises from persistent diabetes Mellitus and high blood pressure; both gradually harms the tiny blood vessels and filtering units within the kidneys.
- Other contributing factors which includes inflammatory kidney conditions such as Glomerulonephritis, inherited disorders like polycystic kidney disease, repeated kidney infections, urinary tract obstructions and a history of acute kidney injury. Prolonged use of certain medications, particularly non-steroidal, anti-inflammatory drugs (NSAIDS) and other toxic substances to kidney tissue also play a significant role.
- The likely of developing CKD increases with the age and is greater among individuals with a family history of kidney problems. Social and

authentic disparities further influence this risk as people in deprived or minority communities often face a combination of genetic vulnerability and unequal access to health Care.

- According to NICE (2021) and kidney care UK (2024), early detection of high-risk patients within primary care settings is crucial to prevent progression and ensure timely management.

Impact of Chronic kidney disease: Physical Psychological and social

- The effects of chronic kidney disease (CKD) mostly depends on how advanced the condition is. In the early stages, many people have no noticeable symptoms and may be unaware of their kidney health. As chronic kidney disease (CKD) gets worse , it can start to take a real toll on a person's body and affects the day to day life. People often feel tired, experience symptoms such as itchy or dry skin , nausea and swelling in their legs and causes Periorbital edema (buildup of fluids in the tissues surrounding eyes) which makes it harder to breathe. Other problems like anaemia , bone weakness or changes in blood chemistry such as high potassium can develop

and increase the risk of heart issue and also creates day to day underline health condition called fatigue where performing tasks becomes more tiring which takes the independence away. Living with chronic kidney disease (CKD) can be challenging emotionally as it is physically. Many people experience anxieties , sadness or frustration especially when thinking about the possibility of dialysis or a transplant worries about the future along with the constant demands of medical appointments. These changes in lifestyle can take a real toll in mental health, overall well being. Offering emotional support and counselling may create a safe spaces to talk openly about fears and concerns which are essentials part of caring for the whole person and not just the disease.

- Living with chronic kidney disease (CKD) can affect more than just a physical health, however it can affect every part of daily life. Many people struggle to keep up with work because of fatigue or frequent hospital visit while others lean on family or carers for support. Factors such as cost of travels, special diets and taking time off from work can also add financial pressure. CKD can

also make people feel isolated or left out from attending social activities. Those in scheduled cast may face even greater challenges with later diagnoses as they often have lack of resources available to them like fewer specialist services and poorer outcomes by providing education , early support and community based care. we can help everyone with CKD live fuller more connected lives .

- **Theoretical perspectives and models towards better result:**

UK model: comprehensive model

- NHS England comprehensive model of personalized care focuses on putting people at the centre of their own health journey for those living with Chronic kidney disease (CKD), this means receiving care that's shaped around their individual needs and goals about making sure they have the right information to get supported and confidence to make informed choices about their treatment and everyday well being. It encourage people to make informed choices and take an active role in managing their conditions. patients work closely with their healthcare teams to design care plans that truly reflects their needs

and priorities.

- NHS England approach to personalized care focus on putting people at the centre of their health supporting them to live well with long term conditions such as chronic kidney disease. These models build around six elements that help ensure care tailored, empowering and centred on what matters most to each individual

1.Personalised care and support planning:

patients work together with their healthcare teams to create care plans that reflects their individual needs preferences and circumstances. this ensures treatments fits their personal goals and what matters most in their daily life.

2.Shared decision-making: people are fully involved in making decisions about their care. They discuss options with their health care professionals making sure every choice reflects their own values, priorities and comfort level.

3.Supported self-management: patients are encouraged and supported to take an active role in managing their conditions. When they have right guidance, they can build confidence and independence in looking after their health is crucial.

4.Health and wellbeing coaching: trained

professionals work along sides with patients to help them develops practical skills, set realistic goals and overcomes challenges in managing their health and well being.

5.Social prescribing: health care teams helps people to connect to local resources such as exercise groups, social clubs, counselling or advising services. Availability of above mentioned supports would not only support physical health but also emotional and social well being of the patient.

6.Personalised health budgets and coordinated care:

When appropriates patients can access funding and services that makes it easier to coordinate care across different providers. This approach helps ensure the system works around the person and not the other way around **by focusing on these six by areas**, care becomes more than just tracking test results or meeting medical targets.

- It's about seeing the whole person-understanding their physical, emotional, and social needs and providing support that genuinely improves their quality of life and not just their clinical outcomes. Research shows that when people feel listened to and involved in their care, they're more likely

to follow treatment plans, feels less anxious, and take a more active role in managing their health.

- Holistic needs assessments are an important part of this approach. They help healthcare professions understand not only the physical effects of chronic kidney disease (CKD) but also the emotional and social challenges that comes with it.
- The aim is simple to provide care that truly listens to what matters most to each person and not just their test results. When patients are actively involved in planning their care, they feel more understood and empowered. Research shows that this kind of partnership helps people stick to their treatments, feel less anxious, and gain a stronger sense of control over their health an well being.

International model: Chronic Care Model (CCM)

- The chronic care model developed by Wagner, highlights six key elements that make managing long term conditions more effective. These include helping patients take an active role in managing their own health, designing care systems thoughtfully, providing clear guidance for

decision-making, using reliable clinical information systems, building supportive healthcare organisations, and linking with community resources.

- When applied to chronic kidney disease the model promotes care that is proactive based on best evidence and delivered by coordinated, multidisciplinary teams. It also places strong emphasis on using patient data to guide decisions and track outcomes, aiming to create well informed empowered patients and responsive well prepared care teams.
- In practice, many kidney services in the UK and beyond already reflect these principles, even if they aren't formally described as part of the CCM.

Policy and political context:

- The way chronic kidney disease is managed in the UK is shaped by both national and local priorities. the NHS long term plan focuses on preventing illness detecting conditions earlier and managing long term health issues effectively with in primary care. CKD fits into this vision through initiatives linked to cardiovascular disease,

diabetes and reducing health inequalities as well as through regular eGFR testing and CKD registers in GP practices.

- National guidance Such as NICE NG203 (2021) sets clear standards for how CKD should be assessed and treated at the same time integrated care systems are responsible for commissioning both renal and community services which helps to create smoother and more coordinated care for patients.
- Despite these positive steps, kidney charities and professional bodies have raised concerns that CKD still doesn't receive the level of attention it deserves. Given its impact on people's lives, kidney research UK (2023) has described CKD as a public health emergency and called for it to be included in the government major conditions strategy. The charity has urged for greater investments in early diagnosis, wider access to effective treatments such as SGLT2 inhibitors, expansion of transplant services and a better psycho-social support for patients and families.
- Support for carers also remains a key part of this picture. Legislation like the care act 2014

provides important protection by ensuring that those caring for people with CKD especially individuals on dialysis or requiring daily assistance are properly assessed and supported.

- The **NHS long term plan** sets out clear priorities for the future of health care, including providing more care closer to homes and focusing on prevention rather than just treatment.
- The NHS long term plan aims to bring more care into community settings make better use of digital technology and place greater emphasis on prevention. These priorities align closely with the goals of preventing chronic kidney disease (CKD) and supporting patients to manage their conditions closer to home.
- This move towards personalised care which is also central part of this version. It encourages people to take an active role in their health making informed choices, managing their conditions with the right support and working in partnership with their healthcare teams when these principals are applied to CKD services they can help improve quality of life, building confidence and ensuring that it truly reflects what matters most to each individual.

- **Person centred care:**
- Management of CKD aims to slow disease progression, reduce complications, and support the best possible quality of life.

Key elements include:

- **Lifestyle:** stop smoking, maintaining a healthy weight, staying physically active, reducing salt intake, eating a balanced diet, and staying up to date with vaccines such as influenza and pneumococcal (NHS, 2023).
- **Blood pressure control:** ACE inhibitors or ARBs are recommended, especially in proteinuria CKD, to lower the progression and cardiovascular risk (NICE, 2021).
- **Glycaemic control:** optimising diabetes management. SGLT2 inhibitors, like dapagliflozin, are now recommended for many adults with CKD, with or without diabetes, to slow progression and reduce kidney failure risk (NICE TA775, 2022).
- **Management of complications:** treating anaemia with iron and erythropoiesis-stimulating agents, addressing bone and mineral disorders with phosphate binders and vitamin D analogues, managing fluid balance with diuretics, and using

statins to reduce cardiovascular risk. Most people with early-stage CKD are cared for in primary care following NICE guidance and the Quality and Outcomes Framework. Those with advanced CKD, rapid decline, heavy proteinuria, or uncertain diagnosis are referred to nephrology. When eGFR drops below around 15 mL/min/1.73m² and symptoms develop, renal replacement therapy options such as haemodialysis, peritoneal dialysis, or kidney transplantation are considered.

- For some, particularly frail older adults, conservative (non-dialytic) management is a valid, person-centred choice. Care is delivered by multidisciplinary NHS teams, including nephrologists, nurses, dietitians, pharmacists, and social workers, who work closely with patients and families to provide support, education, and guidance tailored to individual needs. Availability of Emotional and practical support will also be needed to people who are diagnosed with CKD.
- **Prevention strategic:** Chronic kidney disease (CKD) is a serious condition, but it can be managed effectively, and many people live well

with it. While the disease can be complex and sometimes costly. There are proven ways to slow its progression, prevent complications and support independence. The best results come from care that is integrated and centred on the person focusing on early detections, effective medical management. Emotional and social support, healthy lifestyle choices and decisions made together with patients are also crucial.

- In the UK and around the world health care policy and advocacy are moving towards a model that empowers both patients and their carers. Addresses health inequalities and provides compassionate support at every stage of the condition including end of life care when needed. This holistic approach not only strengthens trust between patients and healthcare teams but also improves overall well being ensuring that no one faces kidney diseases alone.

Recommendation for practice

1. Increase in targeted testing in primary care
Identifies people at higher risk of CKD using eGFR and ACR tests, and keep CKD registers up to date.
2. Use risk assessment tools: Apply tools like the

Kidney Failure Risk Equation (KFRE) to guide referrals, care planning, and prioritise patients who are most at risk.

3. Embed personalised care: Encourage shared decision-making, support self-management, and connect patients to community resources through social prescribing.
4. Provide structured education and remote support: Offer education programmes for people with CKD and use remote monitoring to reduce unnecessary clinic visits.
5. Include CKD in public health initiatives: Link prevention efforts to broader strategies addressing obesity, diabetes, high blood pressure, and heart health.
6. Train primary care teams: Ensure staff are skilled in CKD management and have IT systems that flag abnormal results and support patient follow-up.
7. Address health inequalities: Reach out to scheduled cast communities, minority groups, and socially vulnerable populations to improve access and care.
8. Plan dialysis and transplant services carefully: Emphasise home-based treatments and pre-

emptive transplantation when appropriate.

9. Prevent acute kidney injury (AKI): Strengthen measures across care settings to reduce the risk of CKD progression.
10. Early palliative care and advance planning: Involve palliative care early and support advance care planning for patients not suitable for renal replacement therapy.
11. Support mental health and wellbeing: Recognise the emotional impact of CKD and provide support for both patients and their careers.
12. Encourage research participation people and quality improvement initiated to continuously improve CKD outcomes.
13. Regularly review and audit CKD services to ensure equity, efficiency, and compliance to national guidelines.

14. we are committed to supporting patient's advocacy and engagement, making sure that patient voices truly shape how services are delivered and developed

Conclusion

- Chronic kidney disease is a serious but manageable condition which affects many people across all communities and worldwide. While it's

complex and it can be costly, there are, many proven ways to slow its development, prevent complications, and help people live well and healthy.

- The best outcomes come from integrated model which is, person-centred care that focuses on early detection, good medical management, emotional and social support, healthy lifestyle choices, and decisions made jointly with patients.
- Across the UK and internationally, healthcare policy and advocacy are moving toward a model that empowers individuals and their careers, managing their health inequalities, and provides compassionate support at every stage of the illness, including end-of-life care when needed.
- This holistic approach strengthens trust, improves well being, and ensures that no one faces kidney disease alone many peoples have diagnosed.

References:

1. Levin, A., Stevens, P.E., Bilous, R.W., Coresh, J., De Frances, G., De Jong, P.E. et al., 2013. Kidney disease: improving global outcomes (KDIGO) 2012 clinical practice guideline for the evaluation and management of chronic kidney disease. *Kidney International Supplements*, 3(1), pp.1-150.

2. National Institute for Health and Care Excellence (NICE), 2021. Chronic kidney disease: assessment and management. NICE guideline NG203. London: NICE.
3. Kidney Care UK, 2024. Failure to recognise the seriousness of CKD is costing lives. London: Kidney Care UK.
4. UK Kidney Association, 2023. UK KA 26th Annual Report Chapter 1 – CKD – 2024-07-07. London: UKKA.
5. Hemmelgarn, B.R., James, M.T., Manns, B.J., Klarenbach, S.W., Quinn, R.R., Ravani, P. et al., 2016. The risk of acute kidney injury associated with outpatient exposure to non-steroidal anti-inflammatory drugs among older adults with chronic kidney disease. *BMJ Open*, 6(1), e010195.
6. Coresh, J., Selvin, E., Stevens, L.A., Manzi, J., Kusek, J.W., Eggers, P. et al., 2007. Prevalence of chronic kidney disease in the United States. *JAMA*, 298(17), pp.2038-2047.
7. Webster, A.C., Nagler, E.V., Morton, R.L., Masson, P., 2017. Chronic kidney disease. *The Lancet*, 389(10075), pp.1238-1252.
8. KDIGO Work Group, 2020. Precision medicine in kidney disease: the roadmap. *Kidney International*, 98(6), pp.1174-1180.
9. Alicic, R.Z., Rooney, M.T. & Tuttle, K.R. (2017).

Diabetic Kidney Disease: Challenges, Progress, and Possibilities. *Clinical Journal of the American Society of Nephrology*, 12(12), 2032-2045. <https://doi.org/10.2215/CJN.11491116>

10. Currie, G., Stenvinkel, P., Johnson, R.J., Ketteler, M., 2019. Uric acid, progression of chronic kidney disease and cardiovascular risk: A Mendelian randomisation study. *Journal of the American Society of Nephrology*, 30(10), pp.1793-1805.

11. Hill, N.R., Fatoba, S.T., Oke, J.L., Hirst, J.A., O'Callaghan, C.A., Lasserson, D.S., Hobbs, F.R., 2016. Global prevalence of chronic kidney disease – a systematic review and meta-analysis. *PLoS One*, 11(7), e0158765.

12. National Institute for Health and Care Excellence (NICE), 2022. Sodium-glucose co-transporter-2 (SGLT2) inhibitors for treating chronic kidney disease (TA775). London: NICE.

13. Kidney Research UK, 2023. Economics of kidney disease full report. London: Kidney Research UK.

14. Public Health England, 2022. Health Survey for England 2021: kidney disease – summary of key findings. London: UK Health Security Agency.

15. Sharif, A., Woywodt, A., Szczech, L., Torres, A., 2021. Optimising early detection and referral in chronic kidney

disease. *Nephrology Dialysis Transplantation*, 36(6), pp.1010-1019.

16.Plantinga, L.C., Crews, D.C., Coresh, J., Miller, E.R., Saran, R., Messer, K. et al., 2010. Prevalence of chronic kidney disease in US adults with undiagnosed diabetes or hypertension. *Clinical Journal of the American Society of Nephrology*, 5(2), pp.173-182.

17.MacLeod, A.M., Mitchell, S., 2020. Health inequalities in chronic kidney disease: A systematic review of area-level indicators. *International Journal for Equity in Health*, 19(1), 1-14.

18.James, M.T., Hemmelgarn, B.R., Tonelli, M., 2010. Early recognition and prevention of chronic kidney disease. *The Lancet*, 375(9722), pp.1296-1299.

19.Wiggins, K.J., 2016. "It's not just about survival": health-related quality of life in chronic kidney disease. *Nephrology*, 21(9), pp.705-713.

20.Orlic, L., 2016. Psychosocial aspects in patients with chronic kidney disease. *World Journal of Nephrology*, 5(1), pp.24-32.

21.Gordon, E.J., Wolf, M., 2014. Identifying and addressing psychosocial needs in patients with chronic kidney disease. *Advances in Chronic Kidney Disease*, 21(2), pp.191-200.

22.Howie, A.J.M., 2022. Multidisciplinary care for chronic

kidney disease: best practice models. *Renal Society of Australasia Journal*, 18(1), pp.34-44.

23.Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., Bonomi, A., 2001. Improving chronic illness care: translating evidence into action. *Health Affairs*, 20(6), pp.64-78.

24.Bodenheimer, T., Wagner, E.H., Grumbach, K., 2002. Improving primary care for patients with chronic illness: the Chronic Care Model, Part 2. *Joint Commission Journal on Quality and Safety*, 28(12), pp. 646-656.

25.NHS England, 2019. The NHS Long Term Plan. London: NHS England.

Craig, J., Maguire, K., Devitt, H., 2021. Shared decision-making in chronic kidney disease: concepts and interventions. *Kidney International Reports*, 6(4), pp.956-963.

26.Ferguson, T.W., Komenda, P., Tangri, N., 2019. Risk calculators in chronic kidney disease: use of the kidney failure risk equation. *Current Opinion in Nephrology and Hypertension*, 28(6), pp.480-486.

27.Flynn, R.A., Kelly, D.M., McClintock, J., 2022. Social prescribing and kidney care: a review of current practice. *Journal of Renal Care*, 48(1), pp.32-38.

Patel, M.R., 2020. Health policy and chronic kidney disease: UK perspectives. *Renal & Urology News*, 19(9),

pp.12-15.

28.Lambers Heerspink, H.J., Stefánsson, B.V., Chertow, G.M., Drozdz, W., Haller, H., Kohan, D. et al., 2020. Dapagliflozin in patients with chronic kidney disease. The New England Journal of Medicine, 383(15), pp.1436-1446.

29.Townsend, N., Wilson, L., Bhatnagar, P., Wickramasinghe, K., Rayner, M., Nichols, M., 2023. Cardiovascular disease in the UK: 2022 results. Heart, 109(13), pp.1083-1090.

30.British Heart Foundation, 2023. UK Factsheet: Cardiovascular disease statistics 2023. London: BHF.

31.NHS Digital, 2022. Health Survey for England 2021, Part 2 – kidney disease. London: NHS Digital.