Conservative management of chronic kidney disease (CKD) may be the most suitable option for patients who already experience a high disease symptom burden and for whom dialysis is not likely to increase either length or quality of life. The National Framework for Renal Services (2005) encouraged renal centres to establish links with palliative care services and draw on their expertise in developing individualised care plans and promoting effective communication between the agencies involved in providing patient care. As part of a quality improvement initiative in response to these guidelines, and the desire to extend the palliative care remit within the Trust, a joint renal and palliative care clinic was set up in 2007. Since this time provision has increased to 3 joint clinics a month in order to meet demand and also to ensure an equitable service is provided across the CKD service. The main aims of the clinic are to enable patients and those important to them to:

1. Have an opportunity to discuss and document advance care planning including identification of their preferences of care and advance decisions to refuse treatment;

2. Address symptom control needs;

3. Facilitate psycho-social support.

**Results:**

From January - December 2017 100% of all new clinic patients were offered the opportunity to discuss advance care planning in the context of having a chronic and potentially life threatening illness. Over a third of the patients completed some form of advance care planning including advanced directive to refuse treatment, preferences of care document, and/or a ‘Co-ordinate my Care’ record.

In 2017 we conducted a patient and carer experience survey of the joint clinics. The results were positive highlighting the value that patients place on having the time to discuss their illness and associated concerns, the importance of appropriate information giving and the opportunity to be involved in planning their future care.

**Challenges and issues:**

As the clinics are on 4 different satellite sites monitoring service provision can be a challenge. A centralised database which tracks clinic attendance and outcomes was set up to assist in this process.

Regular patient case reviews are conducted with the Clinical Nurse Specialists involved in the clinics to ensure governance measures are met. This process also lends itself to a supportive and shared learning model of practice.

**Future plans:**

In the future our aim is to train more Clinical Nurse Specialists within both specialities to run the joint nurse led clinics.

**Conclusions:**

A collaborative approach to providing joint renal and palliative care clinics results in patients and those important to them benefitting from the expertise of both specialities. As the focus of the clinics is to provide therapeutic interventions and the opportunity for patients to be fully involved in their advance care planning it promotes a shared care approach.