RENAL NATIONAL CLINICAL NETWORK

Connecting the Kidney Care Continuum

National Renal Clinical Network mahi in Aotearoa New Zealand

Dr Leanne Te Karu
Co-Lead · Renal National Clinical Network

RSA Conference 2026 · Diversity in Action: Every Voice, Every Patient
Te Pae Christchurch · 17–19 June 2026 · Closing keynote

Health New Zealand
Te Whatu Ora

HE WHAKATAUKĪ

Ehara taku toa i te toa takitahi, engari he toa takitini.



A national clinical network is, by design, a collective endeavour – many hands across the motu, one continuum of care.

THE CONTINUUM

Connecting the kidney care continuum

Kidney disease follows a continuum — from healthy function, through often-silent early CKD, to advanced disease and kidney failure. Connecting these stages is the work.

01

Healthy kidneys

Prevention & early detection

›

02

Early CKD

Damage is often silent

›

03

Advanced CKD

Active care to slow the decline

›

04

Kidney failure

Dialysis, transplant



Kidney supportive care — woven across every stage of the continuum, not only at the end.

THE CASE FOR CONNECTION

Why the continuum matters

Without timely identification and effective management, CKD progresses and the consequences compound.

Each missed transition makes the next stage harder to manage and equity harder to achieve.

- **Cardiovascular disease**
- **Fluid overload**
- **Metabolic disturbance**
- **Kidney failure**

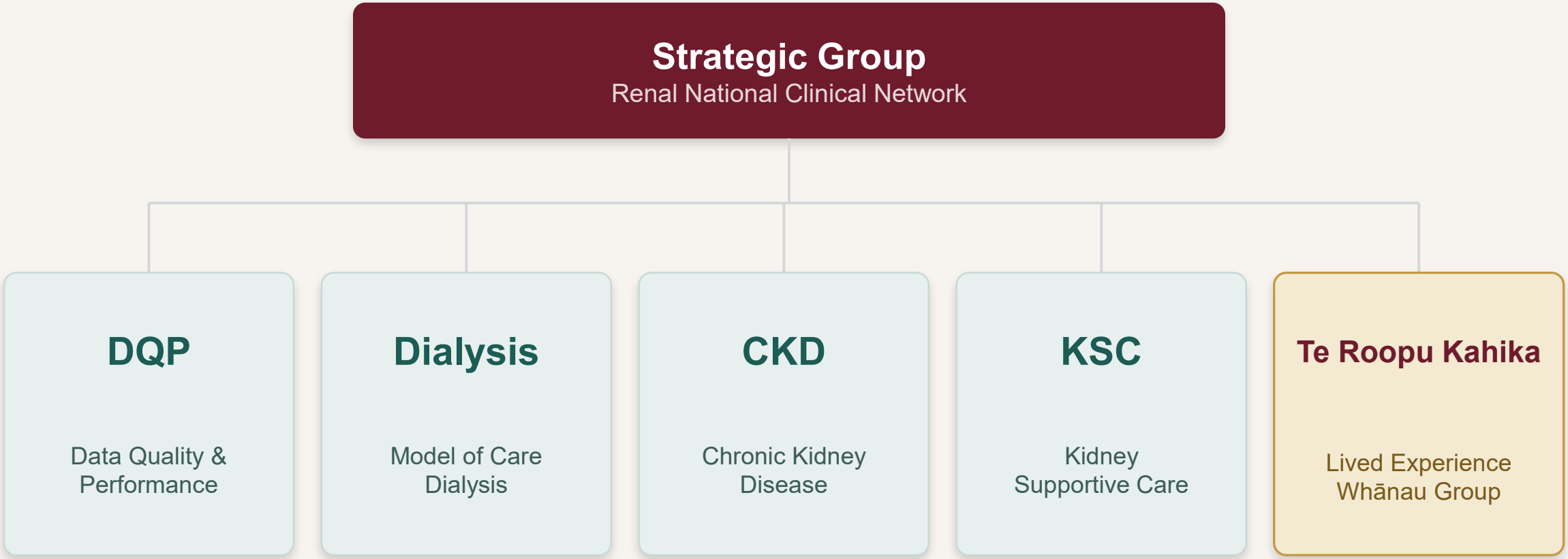
As patients approach end-stage kidney disease, coordinated pathways become critical — making early detection and seamless care across stages essential.

Our vision

To optimise kidney health outcomes across Aotearoa New Zealand through **equitable, integrated, Te Tiriti-led and evidence-informed** care across the full continuum of kidney disease from prevention and early detection through to dialysis, transplantation, and supportive care.

Equitable **Integrated** **Te Tiriti-led** **Evidence-informed**

How we are organised



CURRENT PRIORITIES

Strategic foci

National dialysis service planning

Strengthening how dialysis services are planned across the country.

Early CKD identification & management

Finding and managing CKD earlier, before damage advances.

Data capability

Enhancing the data that drives quality, equity and decisions.

Nationally consistent models of care

Supporting consistent, equitable care wherever people live.

WHAT GUIDES US

Our core principles

Governance partnership Decisions made in genuine partnership.

Eliminating inequities Equity is the measure of success.

Data sovereignty Māori data governed by Māori.

Collaboration with all stakeholders Working across the whole sector.

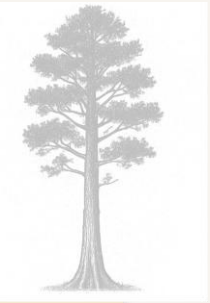
Accountability & monitoring Holding ourselves to account.

TE TIRITI O WAITANGI

Partnership and equity at the centre

Our network is Te Tiriti-led. Partnership, data sovereignty and the elimination of inequities are not add-ons — they shape how we govern, how we prioritise, and how we measure success across the continuum.

Aligned with RSA 2026 — Every Voice, Every Patient.



Te Roopū Kahika

Our Lived Experience Whānau Group ensures that people with lived experience of kidney disease help shape every decision the network makes.

TE RŌOPU KAHIKA

WHĀNAU & CONSUMER VOICE

NATIONAL RENAL CLINICAL NETWORK

OUR ROLE

A strong whānau and consumer voice shaping safer, fairer and more equitable renal services across Aotearoa.

OUR VISION

Whānau feel heard, informed, supported, and connected throughout their renal journey.

OUR FIVE KEY GOALS

1. Whānau-led approaches to improve system change
2. Stronger whānau voice within the Network
3. Identify issues impacting whānau, hapū, and iwi
4. Improved health quality and safety outcomes
5. Te Tiriti o Waitangi obligations upheld

OUR PRIORITY AREAS

STRENGTHENING WHĀNAU & CONSUMER VOICE

- Clear pathways for input.
- Lived experience informs decisions.
- Build leadership and advocacy.

EDUCATION & DECISION SUPPORT

- Identify gaps.
- Culturally appropriate resources.
- Understand care options.

EQUITY & ACCESS

- Remove barriers.
- Fair access for Māori, Pacific, rural and underserved communities.
- Practical solutions.

WHĀNAU EXPERIENCES & INSIGHTS

- Share stories.
- Hui, wānanga and shared learning.
- All voices visible – rangatāhi, whānau, hapū, iwi, rural, Pacific.

PREVENTION & FUTURE FOCUS

- Early intervention and prevention.
- Build knowledge.
- Better outcomes for mokopuna.

HOW WE WILL WORK

- Work alongside whānau, consumers, clinicians and partners
- Hui, wānanga, feedback, storytelling and insights
- Culturally safe and respectful engagement
- Māori data sovereignty and whānau ownership
- Practical improvements that influence services and systems

OUTCOMES WE WANT TO SEE

- Stronger whānau and consumer voice
- Better understanding of care options
- Culturally responsive resources
- Stronger connection to services
- More confidence in navigating the renal journey
- Lived experience drives system change
- Less isolation
- Te Tiriti o Waitangi in action

SUCCESS MEASURES

- Whānau feel heard and respected
- Increased participation of Māori, Pacific, rural and underserved communities
- Stronger relationships between consumers and services
- Practical service improvements influenced by lived experience
- Sustained whānau and consumer leadership

NO WHĀNAU WALKS THE JOURNEY ALONE.

STRONGER VOICE. FAIRER SYSTEM. BETTER FUTURES.

2026 / 27 WORKPLAN

Direction of travel

Indicative priorities — still to be confirmed, but they show where we are heading.



Diagnostic standards & clinical guidance

Standardised national guidance across the pathway.



Digital & data infrastructure

Better data, dashboards and workforce insight.



Renal dialysis roadmap

A national plan for dialysis services.

WORKPLAN · 01

Diagnostic standards & clinical guidance

1 **National referral guidelines**

For nephrology specialist services, with a referral flow chart.

2 **Primary care guideline for early CKD**

Management of early CKD and renal supportive care.

3 **Advocate a national screening programme**

CKD detection within cardiovascular risk assessment.

4 **UACR & CKD coding guidance**

Clear guidance on albumin-creatinine ratios and coding.

5 **Revised IV contrast guidelines**

In partnership with the Radiology National Clinical Network.

6 **Dialysis Technology TAG**

Advising Health Technology Management on dialysis tech needs.

WORKPLAN · 02

Digital & data infrastructure

National kidney health dashboard

Developed and implemented in partnership with PFO.

Workforce modelling

National renal consumer & workforce surveys, 2026.
Kidney DOM

Electronic Quantum forms

Adult renal transplant assessment, Northern Region.

Membership & terms of reference

Reviewing strategic & working-group membership.

- “The most consistent message we hear from Te Roopū Kahika is that many people feel their “kidney disease journey started TOO LATE.”

- Cultural safety
- Social Determinants of Health
- Health Literacy
- Access
- Intersectionality
- Cultural literacy

- Colonisation
- Power and privilege



Population-level CKD care

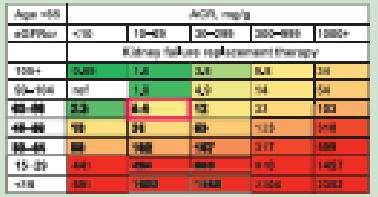
20th century kidney medicine focused on **kidney failure**



Current 21st century kidney medicine: **treat CKD**

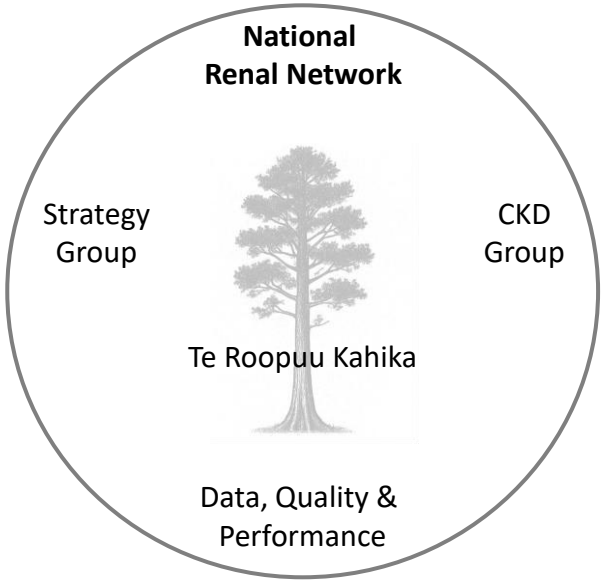


Circa 2030 kidney medicine: **identify & risk-stratify to treat CKD**



Modified from: Ortiz et al.
Nephrol Dial Transplant, 2025, 0, 1–10
https://doi.org/10.1093/ndt/gfaf151

1. Patient & whānau voice **2. Preventable disease** **3. Upstream care delivery vs dialysis capacity crisis**





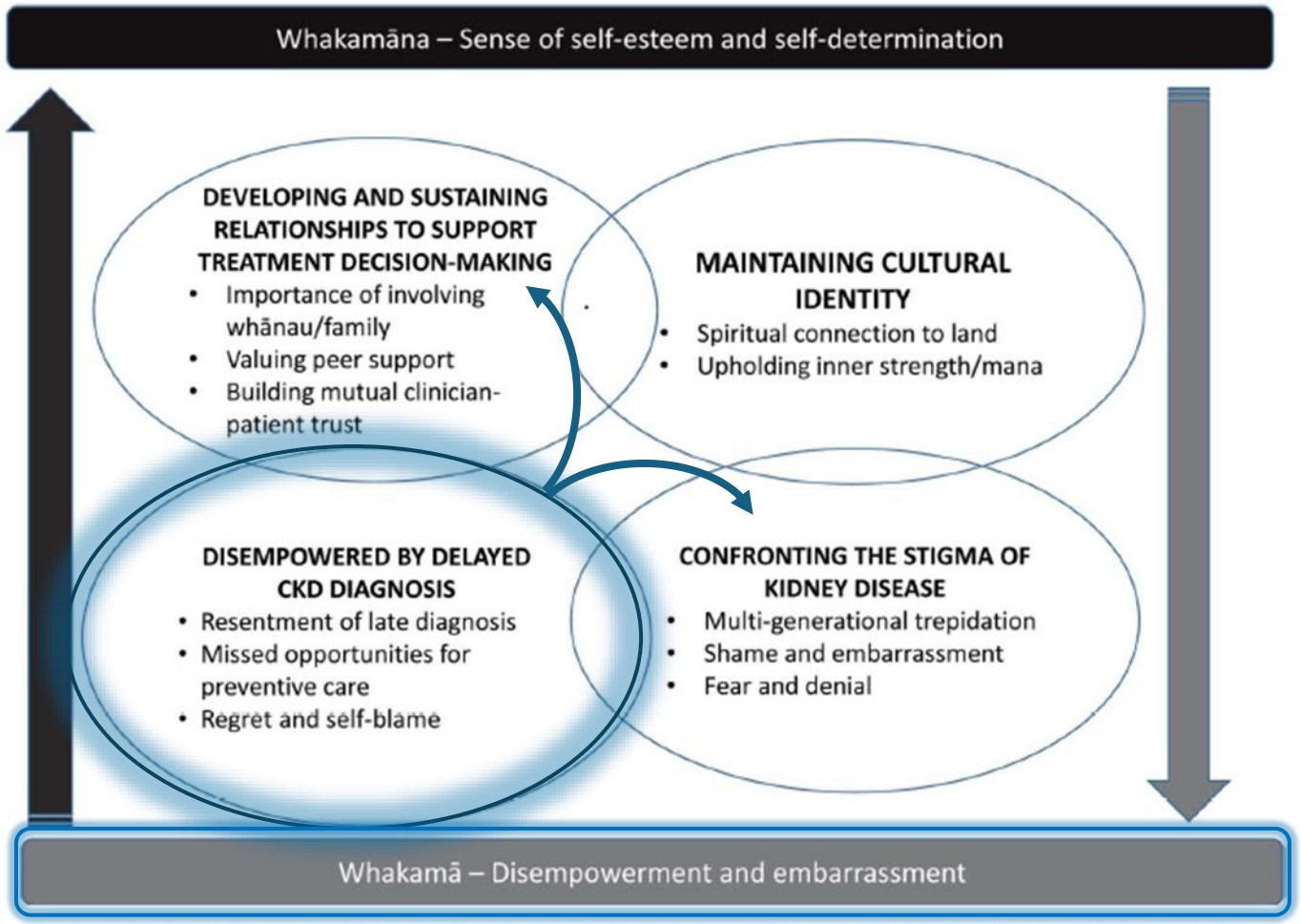
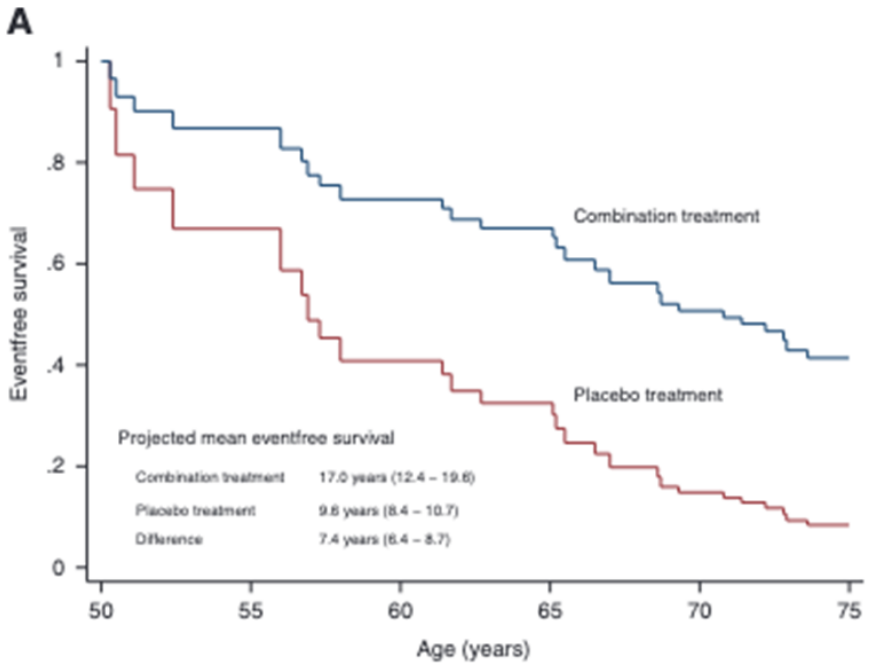


Figure 1 Thematic schema of Māori patients' experiences and perspectives of chronic kidney disease (CKD).

Modified from: Walker et al.
BMJ Open. 2017;7:e013829
DOI: 10.1136/bmjopen-2016-013829

Estimated Lifetime Benefit of Combined RAAS and SGLT2 Inhibitor Therapy in Patients with Albuminuric CKD without Diabetes

Priya Vart,[1,2] Muthiah Vaduganathan,[3] Niels Jongs,[1] Giuseppe Remuzzi,[4] David C. Wheeler,[5] Fan Fan Hou,[6] Finnian McCausland,[3] Glenn M. Chertow,[7,8] and Hiddo J.L. Heerspink[1,9]



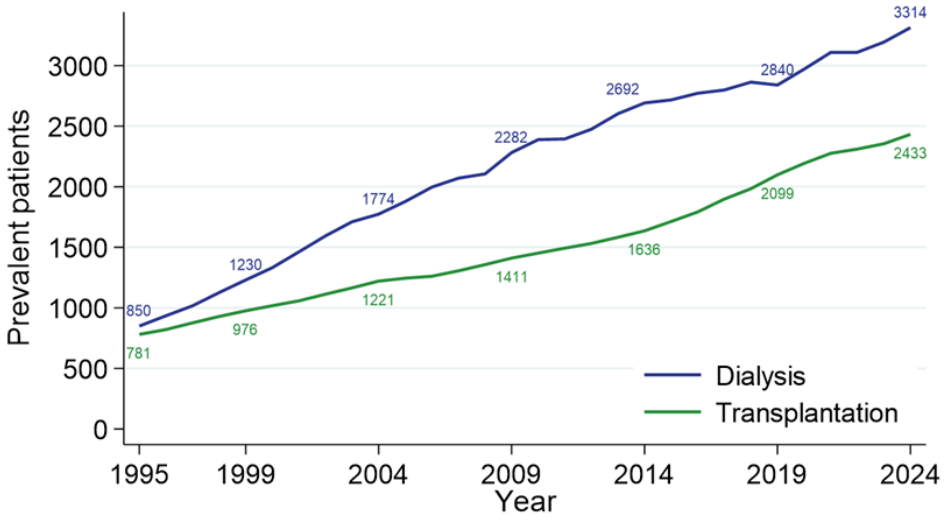
CJASN 17: 1754–1762, 2022. doi: https://doi.org/10.2215/CJN.08900722

ACEi/ARB + SGLT2i *without* diabetes

Results from clinical trials show that an individual aged 50 with albuminuric non-diabetic CKD when treated with **combination ACEi/ARB and SGLT2i** may experience an **additional 7.4 years free of kidney failure and death** compared to placebo

1. Patient & whānau voice **2. Preventable disease** **3. Upstream care delivery vs dialysis capacity crisis**

current state - - - - - - - - - - - - - > future state



2025 ANZDATA Annual Report, Figure 9.8

Prevalence of Dialysis and Transplantation
Aotearoa New Zealand 1995-2024

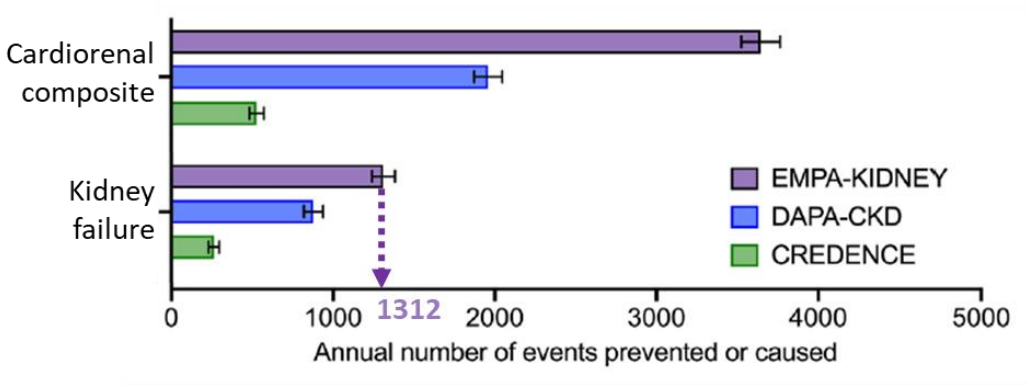


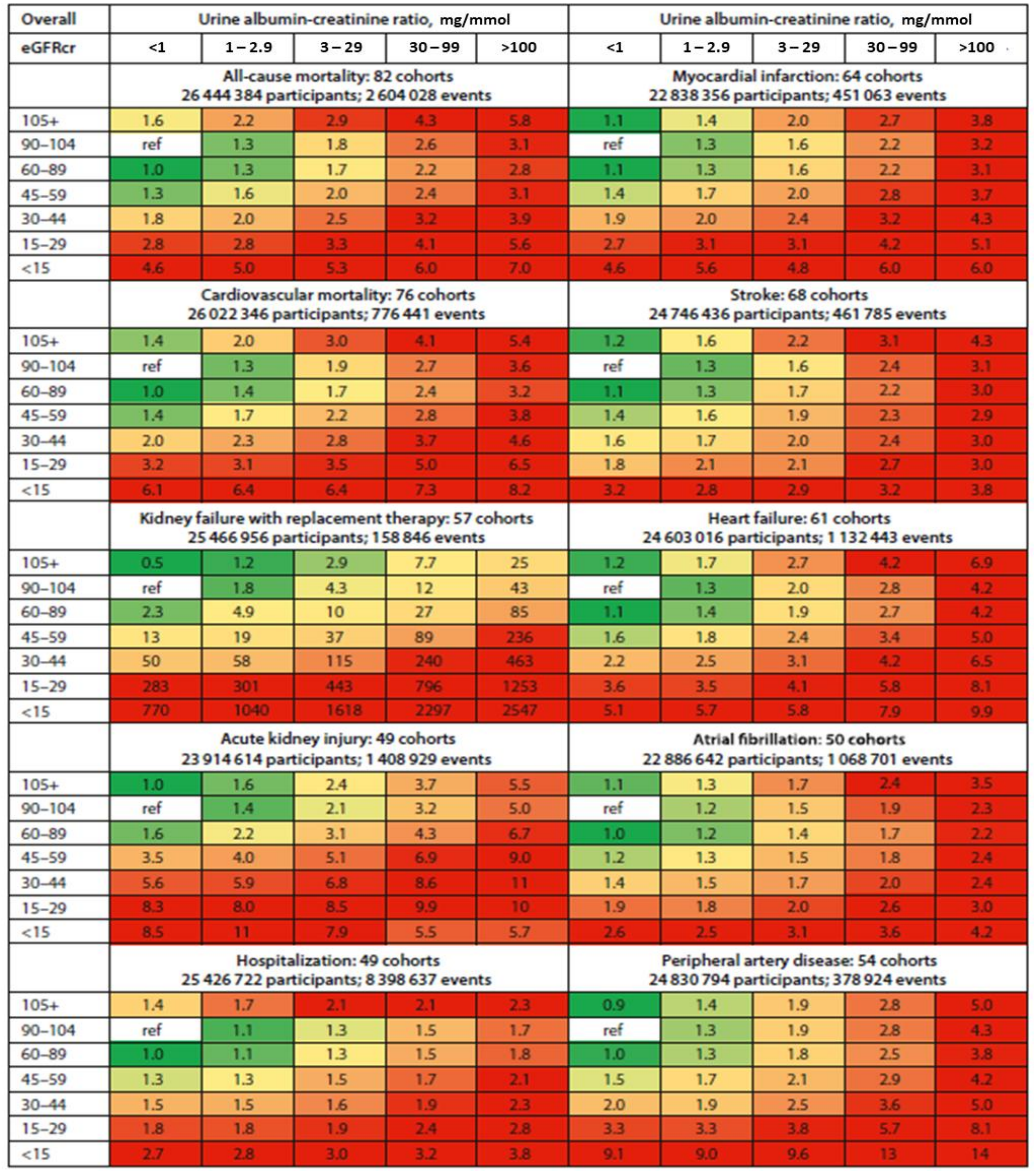
Fig. 3: Estimated annual number of cardiorenal events expected to be prevented in Australia with optimal implementation (75% uptake) of SGLT2 inhibitors in patients with CKD.

annual kidney failure events in Australia in 2022 = 4249,
i.e. reduce annual kidney failure events in Australia by ~30%/year

ANZDATA 2025. Ch 9: Kidney Failure in Aotearoa New Zealand
Available at: http://www.anzdata.org.au

Modified from: Neuen et al. The Lancet Regional Health -Western Pacific. 2024;43: 100988
https://doi.org/10.1016/j.lanwpc.2023.100988

uACR & CKD risk stratification



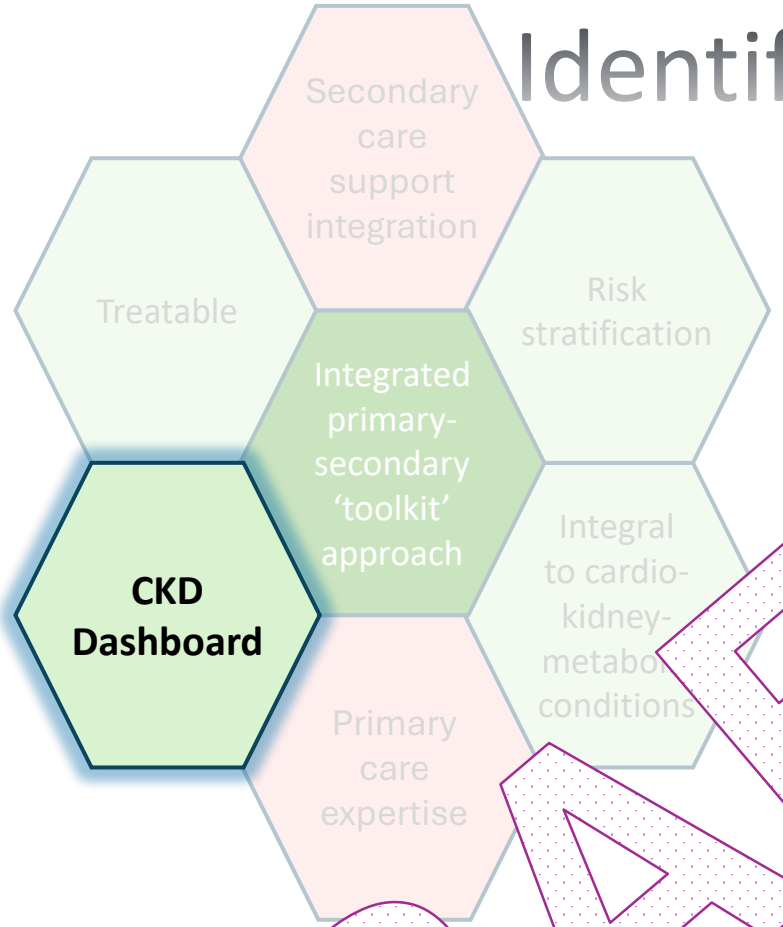
Overall	Urine albumin-creatinine ratio, mg/mmol					Urine albumin-creatinine ratio, mg/mmol				
eGFRcr	<1	1–2.9	3–29	30–99	>100	<1	1–2.9	3–29	30–99	>100
	All-cause mortality: 82 cohorts 26 444 384 participants; 2 604 028 events					Myocardial infarction: 64 cohorts 22 838 356 participants; 451 063 events				
105+	1.6	2.2	2.9	4.3	5.8	1.1	1.4	2.0	2.7	3.8
90–104	ref	1.3	1.8	2.6	3.1	ref	1.3	1.6	2.2	3.2
60–89	1.0	1.3	1.7	2.2	2.8	1.1	1.3	1.6	2.2	3.1
45–59	1.3	1.6	2.0	2.4	3.1	1.4	1.7	2.0	2.8	3.7
30–44	1.8	2.0	2.5	3.2	3.9	1.9	2.0	2.4	3.2	4.3
15–29	2.8	2.8	3.3	4.1	5.6	2.7	3.1	3.1	4.2	5.1
<15	4.6	5.0	5.3	6.0	7.0	4.6	5.6	4.8	6.0	6.0
	Cardiovascular mortality: 76 cohorts 26 022 346 participants; 776 441 events					Stroke: 68 cohorts 24 746 436 participants; 461 785 events				
105+	1.4	2.0	3.0	4.1	5.4	1.2	1.6	2.2	3.1	4.3
90–104	ref	1.3	1.9	2.7	3.6	ref	1.3	1.6	2.4	3.1
60–89	1.0	1.4	1.7	2.4	3.2	1.1	1.3	1.7	2.2	3.0
45–59	1.4	1.7	2.2	2.8	3.8	1.4	1.6	1.9	2.3	2.9
30–44	2.0	2.3	2.8	3.7	4.6	1.6	1.7	2.0	2.4	3.0
15–29	3.2	3.1	3.5	5.0	6.5	1.8	2.1	2.1	2.7	3.0
<15	6.1	6.4	6.4	7.3	8.2	3.2	2.8	2.9	3.2	3.8
	Kidney failure with replacement therapy: 57 cohorts 25 466 956 participants; 158 846 events					Heart failure: 61 cohorts 24 603 016 participants; 1 132 443 events				
105+	0.5	1.2	2.9	7.7	25	1.2	1.7	2.7	4.2	6.9
90–104	ref	1.8	4.3	12	43	ref	1.3	2.0	2.8	4.2
60–89	2.3	4.9	10	27	85	1.1	1.4	1.9	2.7	4.2
45–59	13	19	37	89	236	1.6	1.8	2.4	3.4	5.0
30–44	50	58	115	240	463	2.2	2.5	3.1	4.2	6.5
15–29	283	301	443	796	1253	3.6	3.5	4.1	5.8	8.1
<15	770	1040	1618	2297	2547	5.1	5.7	5.8	7.9	9.9
	Acute kidney injury: 49 cohorts 23 914 614 participants; 1 408 929 events					Atrial fibrillation: 50 cohorts 22 886 642 participants; 1 068 701 events				
105+	1.0	1.6	2.4	3.7	5.5	1.1	1.3	1.7	2.4	3.5
90–104	ref	1.4	2.1	3.2	5.0	ref	1.2	1.5	1.9	2.3
60–89	1.6	2.2	3.1	4.3	6.7	1.0	1.2	1.4	1.7	2.2
45–59	3.5	4.0	5.1	6.9	9.0	1.2	1.3	1.5	1.8	2.4
30–44	5.6	5.9	6.8	8.6	11	1.4	1.5	1.7	2.0	2.4
15–29	8.3	8.0	8.5	9.9	10	1.9	1.8	2.0	2.6	3.0
<15	8.5	11	7.9	5.5	5.7	2.6	2.5	3.1	3.6	4.2
	Hospitalization: 49 cohorts 25 426 722 participants; 8 398 637 events					Peripheral artery disease: 54 cohorts 24 830 794 participants; 378 924 events				
105+	1.4	1.7	2.1	2.1	2.3	0.9	1.4	1.9	2.8	5.0
90–104	ref	1.1	1.3	1.5	1.7	ref	1.3	1.9	2.8	4.3
60–89	1.0	1.1	1.3	1.5	1.8	1.0	1.3	1.8	2.5	3.8
45–59	1.3	1.3	1.5	1.7	2.1	1.5	1.7	2.1	2.9	4.2
30–44	1.5	1.5	1.6	1.9	2.3	2.0	1.9	2.5	3.6	5.0
15–29	1.8	1.8	1.9	2.4	2.8	3.3	3.3	3.8	5.7	8.1
<15	2.7	2.8	3.0	3.2	3.8	9.1	9.0	9.6	13	14

#1
This is about cardiovascular disease, hospitalisation and mortality (*and kidney failure*)

#2
Albuminuria defines risk

Modified from: Grams et al. JAMA 2023;330(13):1266-1277 doi:10.1001/jama.2023.17002

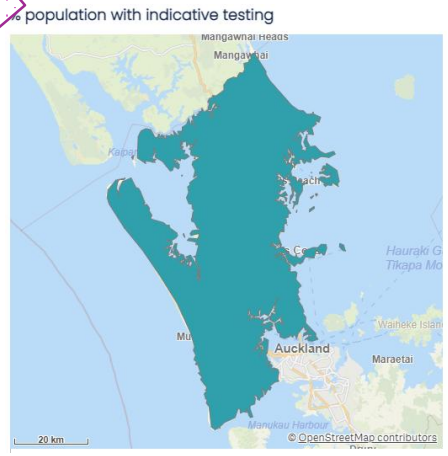
Identifying case volumes & unmet need in CKD

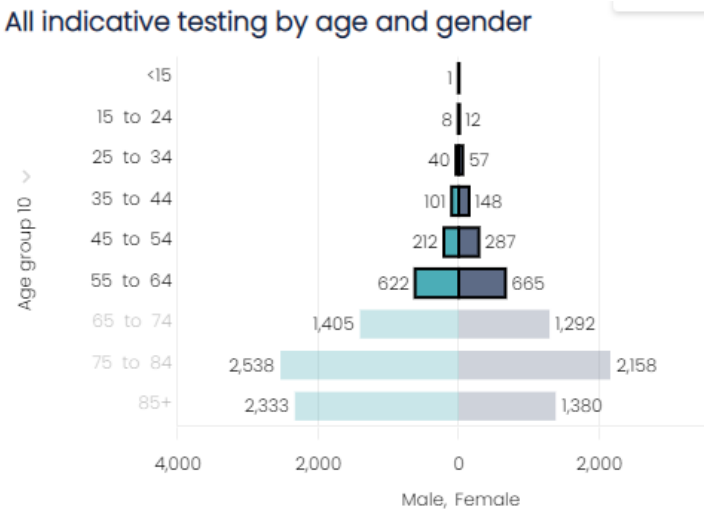


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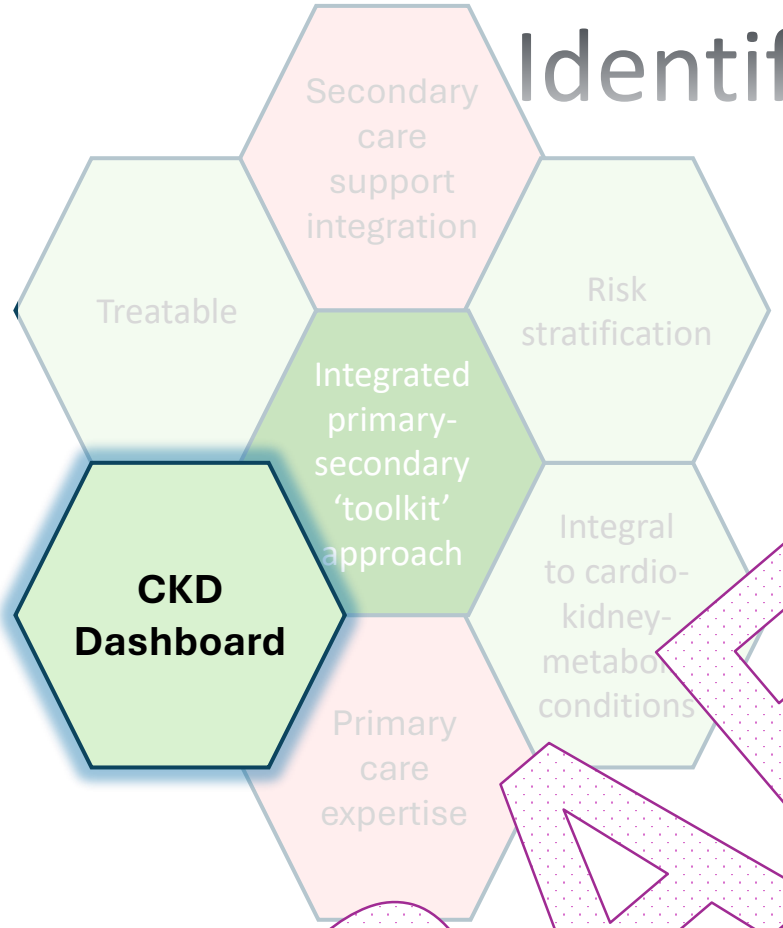
Indicative testing

CALC_EGFR_GR...	PROTEIN_GROUP2				
	Totals	-	A1	A2	A3
Totals	2,153	1,372	575	125	81
G3a	1,857	1,191	543	96	27
G3b	172	105	28	20	19
G4	37	23	2	4	8
G5	87	53	2	5	27





Identifying case volumes & unmet need in CKD

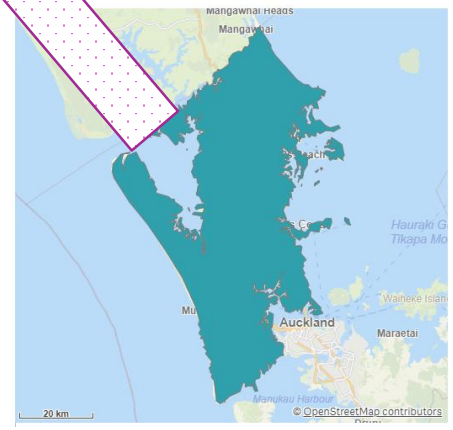


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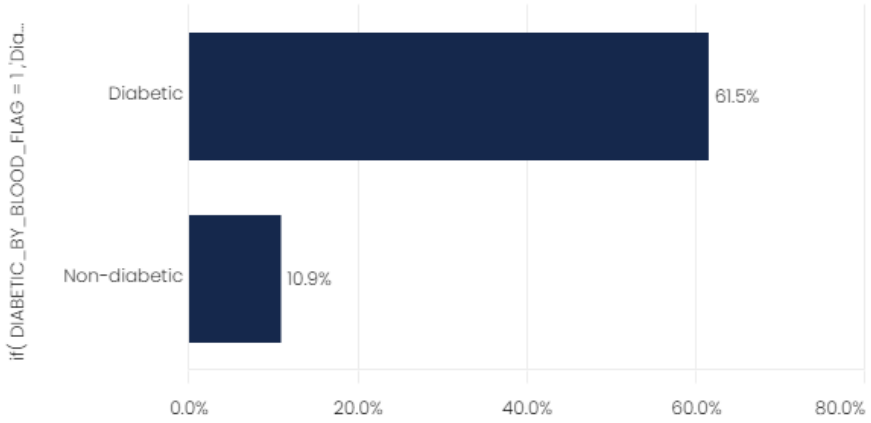
KPI 3a - Appropriate GLP1/SGLT2i usage from KDIGO guidelines

KPI 3a denominator	KPI 3a	Pts with SGLT2i prescribing
1016	40.0%	480

ation with indicative testing

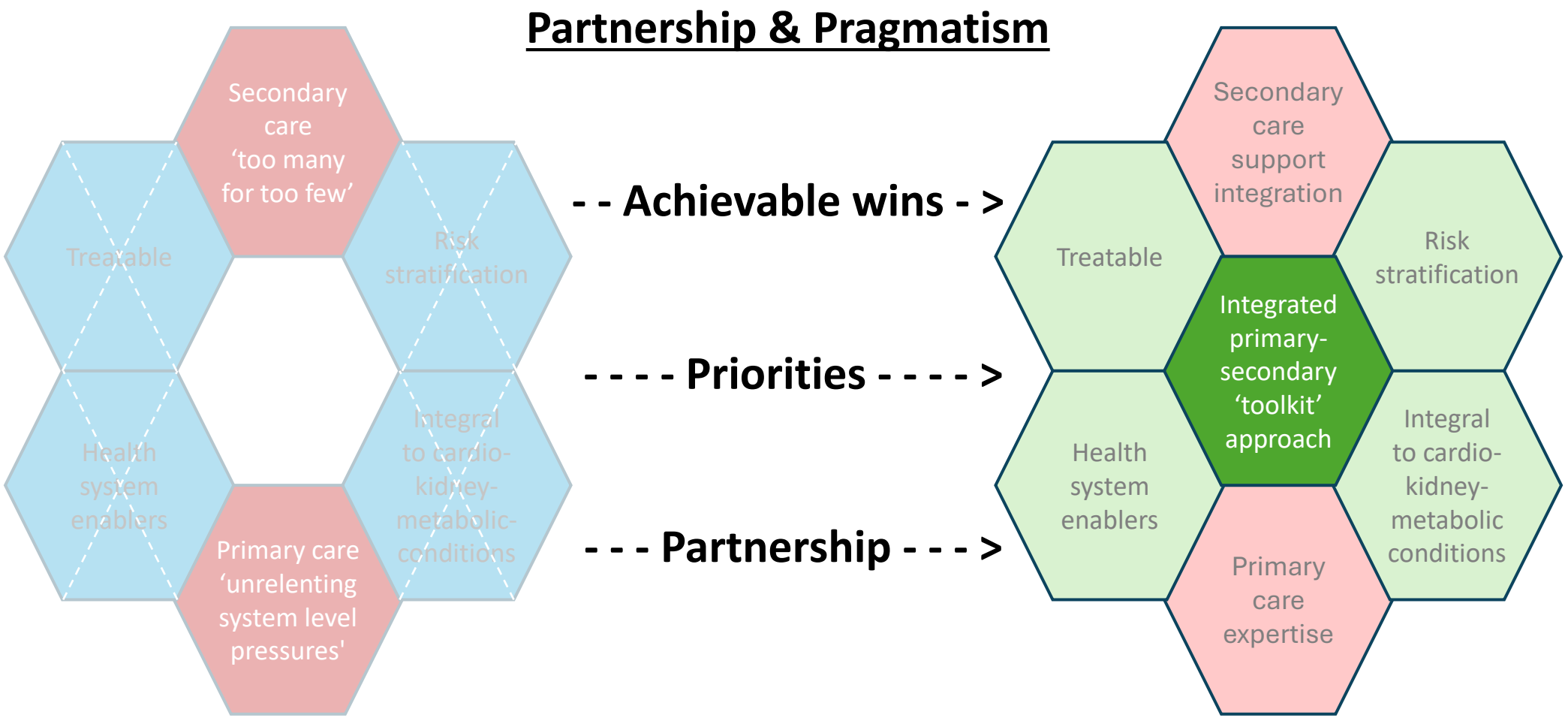


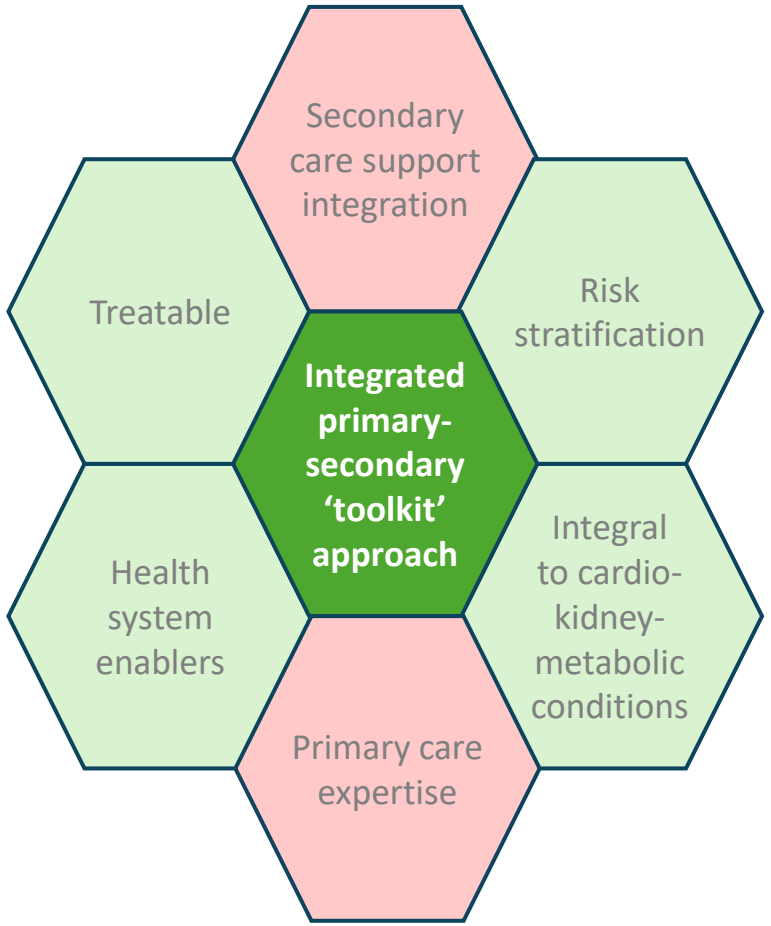
KPI 3a by Diabetes



Population-level CKD care

current state - - - - - - - - - - - - - > future state





Proposed areas for partnership

current state ---> future state

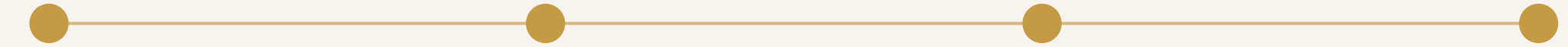
Domain	Current state	Future state achieved by…
CKD coding	K05 : Chronic Renal Failure	Expanded coding options without "failure" term
CKD dashboards	CKD identified *ad hoc*	CKD dashboards - *uACR & eGFR tests (risk stratification, monitoring progression)* - *medicines optimisation* - *timely renal service input* - *sharing from central resource, or sharing code for local resource*
CKD management	Primary care until meets referral thresholds	Develop partnership approach towards business case for workforce & infrastructure growth for integrated primary-secondary care models

Pathology Collaboration

WORKPLAN · 03

A national roadmap for renal dialysis

We are supporting the development of a national roadmap for renal dialysis services, underpinned by robust modelling, so that capacity, equity and sustainability are planned nationally.



Four priorities

Better data

Earlier identification

Nationally consistent care

Sustainable dialysis services

Clinical Services Planning

- Regions operating above capacity, Auckland highest. MODELLING – Helen Eddington
- Capacity modelling excludes acute dialysis spaces to avoid unsafe pressure on acute services.
- Dialysis capacity uplift plan developed with Planning, Funding & Outcomes: Approx. 350 additional dialysis chairs nationally over 10 years.
- Short-term use of third shifts to manage demand while infrastructure is developed.
- Plan iteratively and review regularly.
- Board consideration was scheduled for 3rd June 2026, now July…….
- Christchurch approved for additional nursing FTE as an early response.
- Development underway of a Dialysis Occupancy Measure to monitor real-time capacity and inform future planning.
- Workforce planning recognised as critical beyond nursing and medical, (allied health, admin, support staff).

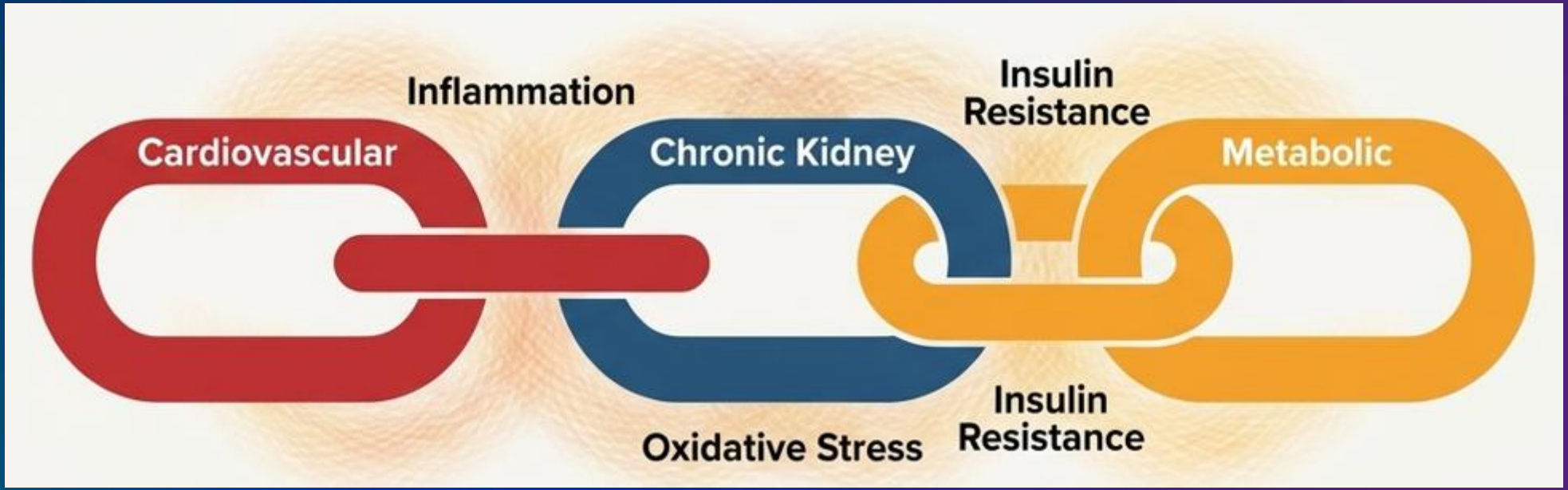
- encourage and facilitate participation in the workforce surveys
- involvement in district-level interviews, to work through the workforce data together

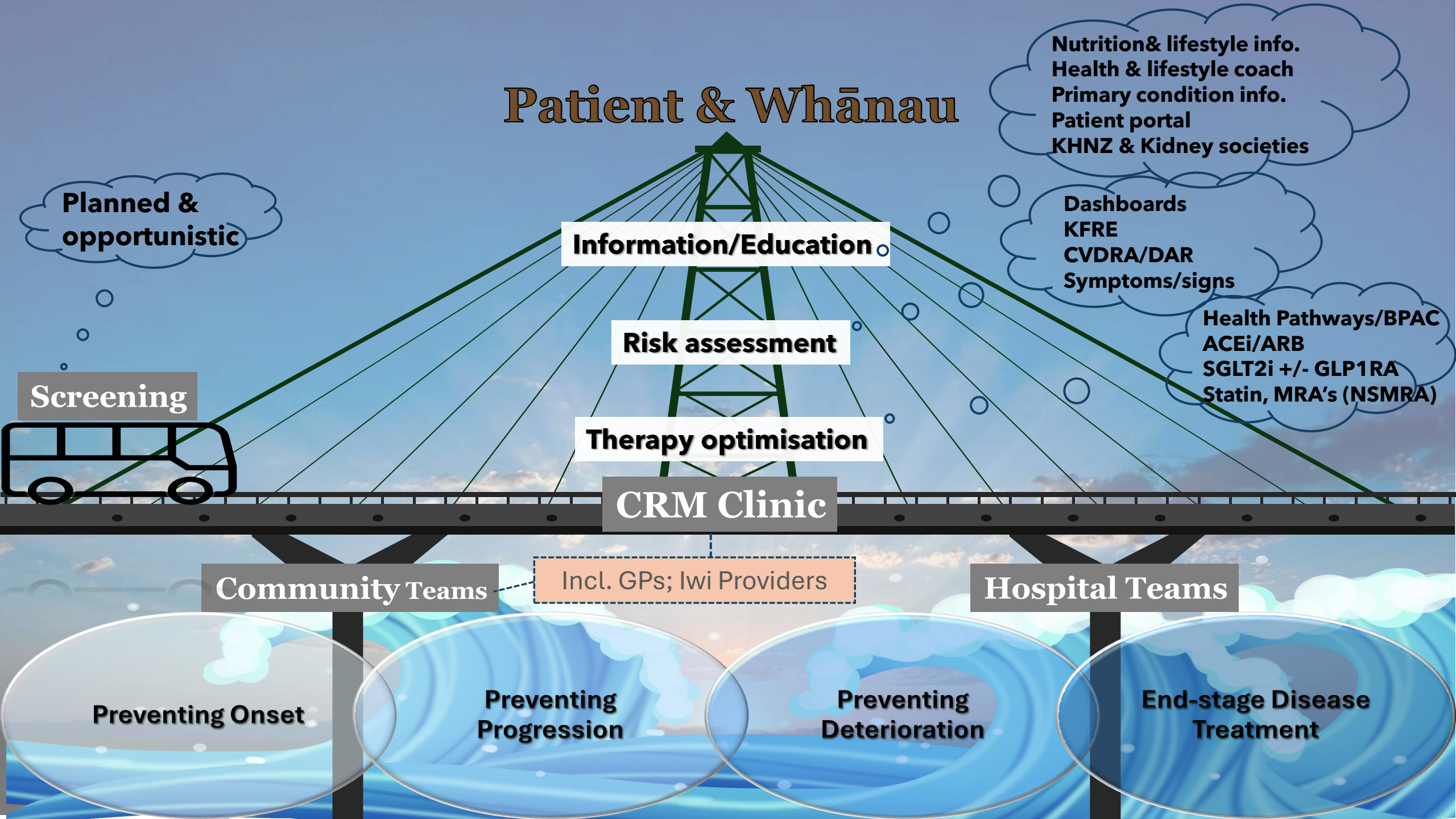


- National Renal Workforce Survey

CKM – Update
Non-communicable disease

From isolated silos to an interconnected syndrome with shared pathophysiology

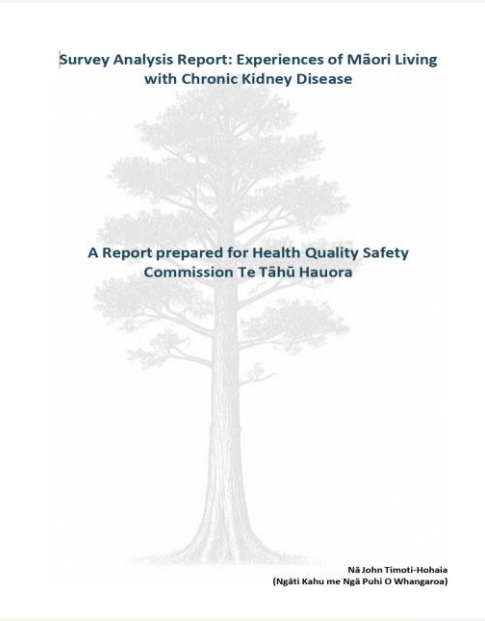



Patient & Whānau
Nutrition& lifestyle info.
Health & lifestyle coach
Primary condition info.
Patient portal
KHNZ & Kidney societies
Planned & opportunistic
Dashboards
KFRE
CVDRA/DAR
Symptoms/signs
Information/Education
Risk assessment
Health Pathways/BPAC
ACEi/ARB
SGLT2i +/- GLP1RA
Statin, MRA's (NSMRA)
Screening
Therapy optimisation
CRM Clinic
Community Teams
Incl. GPs; Iwi Providers
Hospital Teams
Preventing Onset
Preventing Progression
Preventing Deterioration
End-stage Disease Treatment

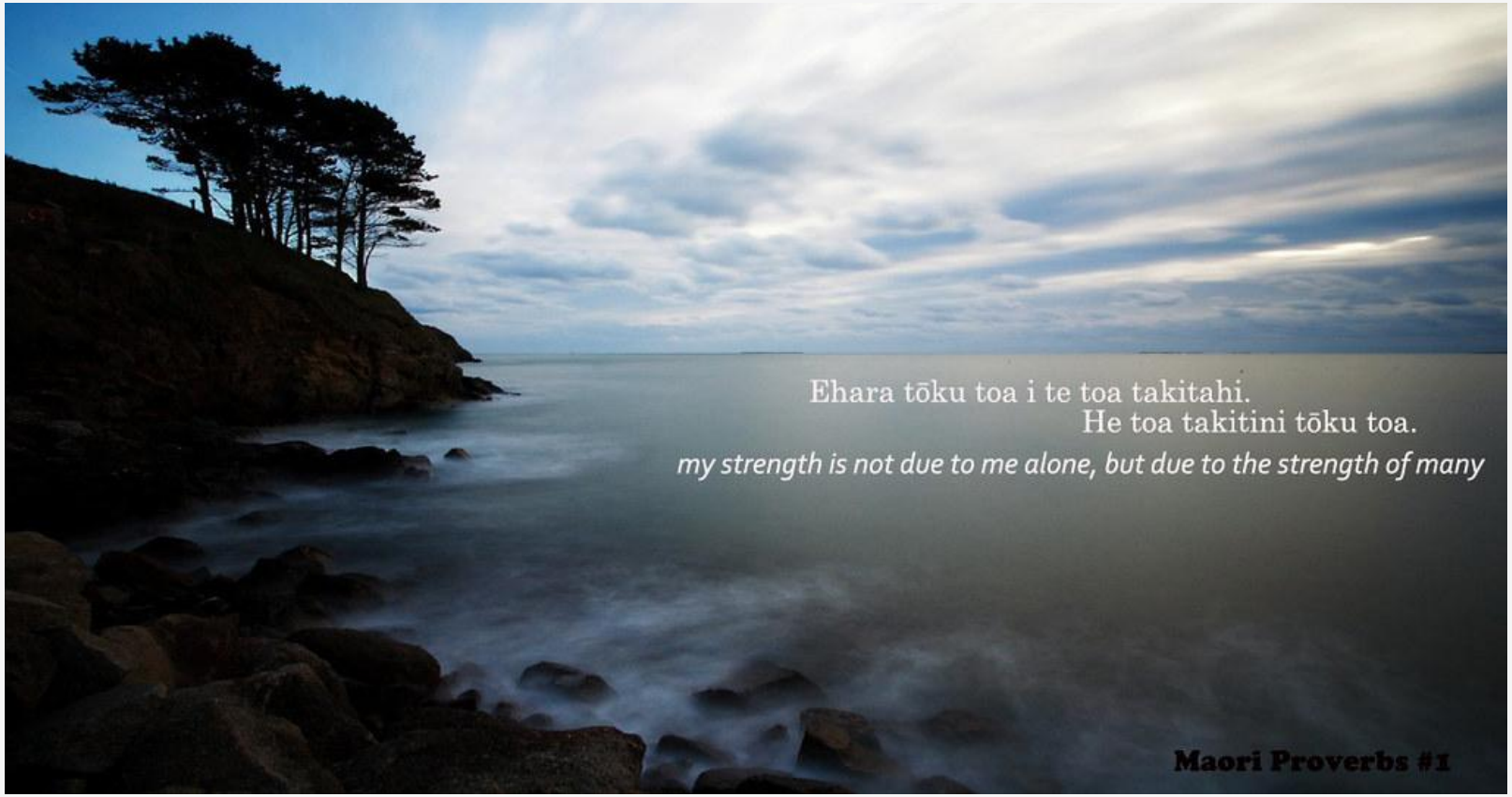
What success looks like

- Fewer people reaching kidney failure
- Earlier diagnosis
- More equitable outcomes for Māori
- Consistent care regardless of postcode
- People and whānau involved in decisions





Collaboration



NGĀ MIHI NUI

Connecting the continuum — together

From prevention to supportive care, no part of the journey stands alone. A connected national network means every voice and every patient is carried across the continuum.

Dr Leanne Te Karu
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Te Kāwanatanga o Aotearoa
New Zealand Government

Health New Zealand
Te Whatu Ora