



Kidney Care

Addressing Low Chronic Kidney Disease Prevalence in Primary Care

Project report

March 2013

Better Kidney Care for All

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1. Introduction

Chronic kidney disease (CKD) is common, harmful and treatable. Epidemiological studies suggest a CKD stage 3-5 prevalence of 6-7% in adults in England and yet only 4.3% are registered as having a diagnosis of CKD on primary care (QOF) registersⁱ – a gap of -33% nationally. There is also significant variation in the recognition of CKD at practice level, with many practices having unexpectedly low CKD prevalence. Failure to recognise CKD early, especially those with significant proteinuria, may lead to adverse outcomes for patients: cardiovascular morbidity and mortality (a key goal to improve in the NHS Mandateⁱⁱ, Outcomes Frameworkⁱⁱⁱ and Cardiovascular Outcomes Strategy^{iv}) and progression to more severe CKD (or end stage renal failure).

In 2012/13 NHS Kidney Care facilitated a project across London to initiate and encourage partnership working within local health economies in order to address variation in the reported prevalence of chronic kidney disease, with the aim of narrowing the prevalence gap in Clinical Commissioning Groups (CCGs) exhibiting the largest variation, and to identify and address practices with lower than expected diagnosis rates. The project encouraged and fostered proactive locally driven working groups, forums and networks comprised of primary and secondary care clinicians and supported the identification of CKD leads in Clinical Commissioning Groups (CCGs) who will champion the screening and recording of CKD. They will work with nephrologists in their referring renal units to address issues including primary care education and referral practices.

2. Background

In 2012 NHS Kidney Care published a report which looked at the social and financial burden of chronic kidney disease in England. The report found that:

- The annual cost of CKD to the NHS in England is estimated at £1.45 billion. This is more than the combined annual cost of breast, lung, colon and skin cancer.
- There may be up to 30,000 people with CKD who could benefit from ACEI/ARB medication and are not currently receiving them.
- Care for a patient on dialysis costs the NHS around £27,000 a year, while the cost of slowing down kidney deterioration is around £235 a year.
- There are approximately 7,000 extra strokes and 12,000 extra heart attacks each year among people with CKD. 'Extra' means over and above those in people of the same age and gender without CKD.

Scoping work in 2011 which involved analysis of 2009/10 Quality and Outcomes Framework (QOF) data for the observed prevalence of chronic kidney disease in primary care revealed that observed/recorded prevalence was significantly lower than the expected prevalence in many practices and regions. The largest "prevalence gap" was in London, where there was evidence that many patients with CKD are being missed, with a ten-fold variation in the identification rate between GP practices in some Primary Care Trust regions.

The 'expected' number of people on CKD registers is an estimate. Expected CKD prevalence is calculated using the combined results of the Health Survey for England (HSE) surveys carried out in 2009 and 2010. HSE is a series of annual surveys which measure health and health related

behaviours in adults and children, in England. In 2009 and 2010 special modules to measure CKD prevalence were added to the core survey.^v

The expected prevalence of CKD for a GP practice or CCG population is standardized for age and gender. However the data is not weighted for other clinical and socio-demographic factors which may affect prevalence (for example deprivation and ethnicity). **However, increasing age is considered the single most significant risk factor for CKD.**^{vi}

In 2012 NHS Kidney Care published CCG Kidney Disease profiles and an accompanying data guide. These can be downloaded from:

http://www.kidneycare.nhs.uk/our_work_programmes/preventing_ill_health/kidney_disease_ccg_profiles/

The Quality and Outcomes Framework^{vii}

The number of people with a diagnosis of CKD is described as the 'observed' number; it represents the number of people on CKD QOF registers. The QOF 2011/12 source data is available at practice level from the NHS Information Centre for Health and Social Care website: <http://www.ic.nhs.uk/qof>

3. Chronic Kidney Disease in primary care

The NICE clinical guidelines published in 2008 (update expected July 2014) provide clinical guidance to primary care clinicians around:

- People who have or are at risk of developing CKD
- Those who need intervention to minimise cardiovascular risk and what that intervention should be
- Those who will develop progressive kidney disease and/or complications of kidney disease and how they can be managed
- Those who need referral for specialist kidney care^{viii}

Within the NICE guidance chronic kidney disease (CKD) is classified into stages one to five. Stage 3 CKD can be sub classified into 3a and 3b with stage 3b experiencing a higher risk of cardiovascular disease and End Stage Renal Disease than those in 3a.(See Figure 1).Patients diagnosed with CKD benefit from treatment proven to reduce mortality and slow progressive decline in kidney function. Diagnosis also highlights patients at risk of greater harm due to medication side effects and acute kidney injury. Patients with CKD Stage 3 should not be referred to secondary care, rather treated and managed by their GP.

Stages of CKD^a and frequency of eGFR testing

Stage ^b	eGFR (ml/min/1.73 m ²)	Description	Typical testing frequency ^c
1	≥ 90	Normal or increased GFR, with other evidence of kidney damage	12 monthly
2	60–89	Slight decrease in GFR, with other evidence of kidney damage	
3A	45–59	Moderate decrease in GFR, with or without other evidence of kidney damage	6 monthly
3B	30–44		
4	15–29	Severe decrease in GFR, with or without other evidence of kidney damage	3 monthly
5	< 15	Established renal failure	6 weekly

Test eGFR^c:

- Annually in all at risk groups.
- During intercurrent illness and perioperatively in all patients with CKD.
- The exact frequency should depend on the clinical situation. The frequency of testing may be reduced where eGFR levels remain very stable but will need to be increased if there is rapid progression.

Figure 1: Stages of CKD

Source- National Institute for Health and Clinical Excellence. Clinical Guidance 73- Chronic Kidney Disease. 2008

4. Identification at Clinical Commissioning Group (CCG) level in London

The project focused on London, where the average CKD prevalence gap is much wider at -47% than for the rest of England at -36%.

A prioritisation exercise was undertaken in the summer of 2012 to rank London Clinical Commissioning Groups (CCGs) by their distance from age and sex standardised estimated prevalence (using QOF data from 2010/11). The findings were then used to inform which CCGs should be engaged in the project. The rankings revealed great variance in the size of the gap from Greenwich at -24% to Westminster at -68% (Figure 2)

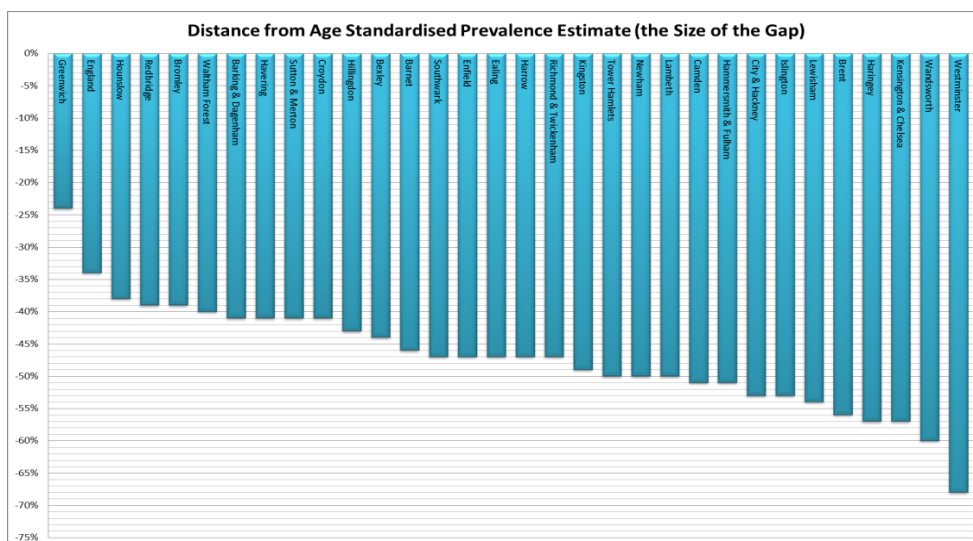


Figure 2: Distance from age standardised prevalence estimate (the size of the gap)

Practice by practice data shows that variability occurs at practice level within London CCGs, meaning that the gap is highly variable within CCGs as well as between them. Even the CCGs with a narrow gap, Greenwich in particular at -24% (the narrowest in London) have some very low reporting practices within them. Figure 3 below illustrates practice by practice variation within Hounslow CCG. Across Hounslow the observed versus expected prevalence gap is -36%. However the range of the gap between practices ranges from -80 to 47%.

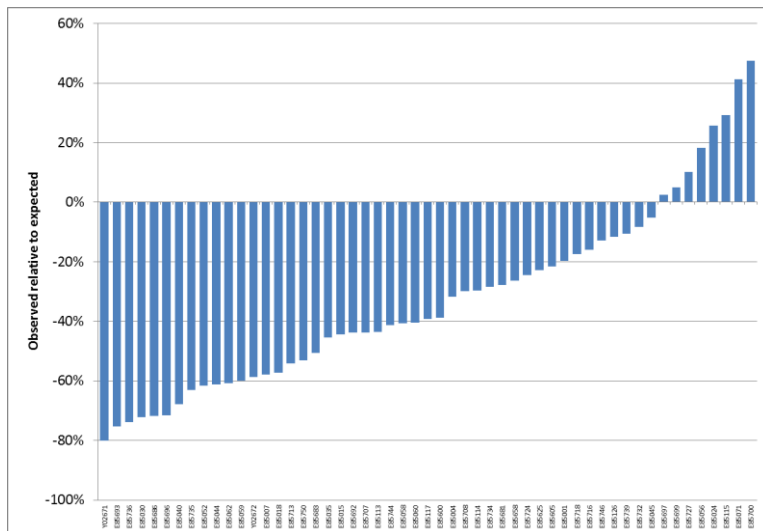


Figure 3: Practice by practice variation within Hounslow CCG

The first phase of the project was to contact all CCGs whose gap was wider than the London average via their GP Chairs and to invite them to participate in project work aimed at reducing their local prevalence gaps. Nineteen London CCGs were invited to engage in the project. Recognition and acceptance of this public health issue was widespread with most CCG Chairs acknowledging that it should be addressed in their areas and agreeing to work in collaboration with NHS Kidney Care.

Discussions with Chairs and other GP leaders at CCG level have helped to inform and refine the possible causes of the gap. Investigation revealed that non-clinical issues were thought to be the main causes.

The project recognised that there are additional factors with no recorded data that may help to determine at what level estimated prevalence should be set. These factors include ethnicity, deprivation, and obesity. With such datasets being unavailable, it was not possible to set estimated prevalence at a level to reflect these additional factors. **Therefore practices with large South Asian populations, high levels of deprivation, and / or obesity may conclude that the published prevalence estimates are set too low and may wish to adjust them upward to get a more accurate picture.** Conversely, practices who have a younger than average patient population or large student population, such as Camden, or are situated in urban areas close to where their patients work, rather than reside, may adjust their prevalence gap downwards.

Following initial discussions, representatives from the following CCGs agreed to participate in tailored workshops and events in partnership with secondary care representatives to establish communities of practice: Brent, Harrow, Ealing, Hounslow, Hammersmith and Fulham, Westminster, Camden, Islington, Hackney, Tower Hamlets, Newham, Haringey, Enfield, Barnet, Southwark, Lambeth and Lewisham.

With the release of 2011/12 QOF CKD data we were able to provide each of the CCGs with more relevant data to inform their planning and actions. NHS Westminster exhibits the largest gap in 2011/12 with -65% as seen in Figure 4.

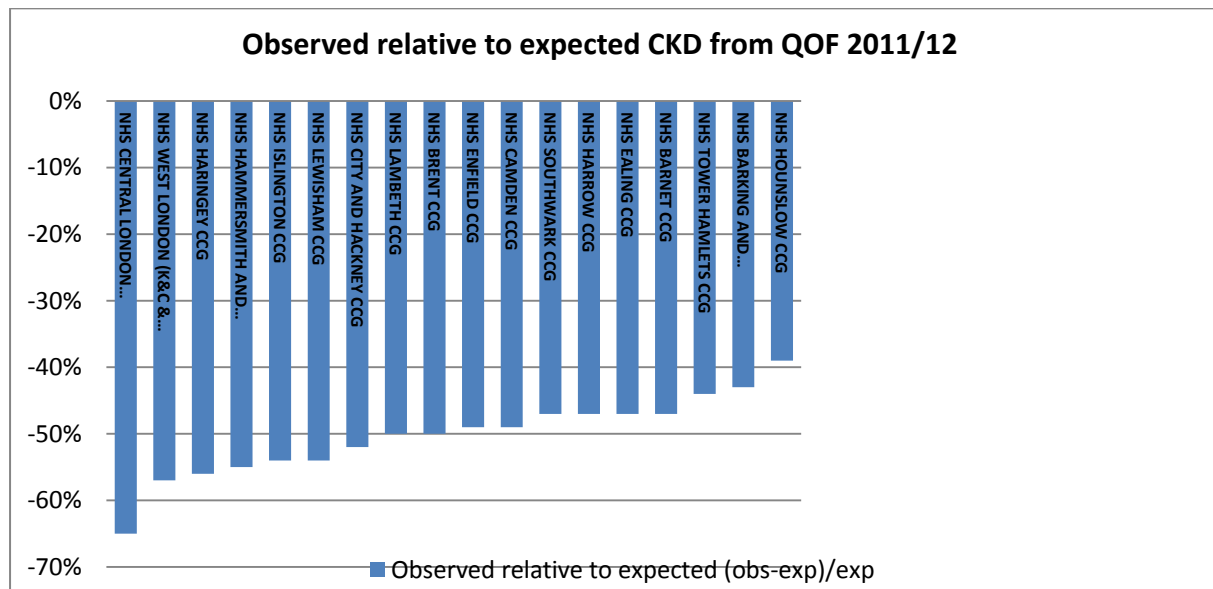


Figure 4: Observed relative to expected CKD from QOF 2011/12

Workshops and tailored CKD Learning Sessions for primary care clinicians were planned across London between September 2012 and January 2013. The aims of the workshops were:

- To form a community of practice in each affected London CCG to address low QOF-reported CKD prevalence in primary care.
- To better understand the causes of low QOF-reported CKD prevalence in each community of practice (addressing both the prevalence gap at CCG level and outlying individual practices).
- To agree a plan of actions and outcomes created by the workshop attendees to address the causes of low QOF-reported CKD, that can be implemented by primary care.

5. Pilot low CKD prevalence workshop in London

The first of the exploratory action planning workshops was hosted collaboratively with Westminster and Hammersmith and Fulham CCGs on 18th September 2012. The workshop was chaired by Dr Tony Hill, a GP from Hammersmith CCG, and Dr Peter Hill, a nephrology consultant from Imperial College Health Care NHS Trust.

This first pilot workshop helped to define and refine the exploration and action planning that was required. 'Missing' patients were segmented into three categories (described below) and participating practices were asked to audit their EMIS/Vision systems to identify them and then to manage and code appropriately.

- (1) **Coding Issues** - CKD patients that are being treated but have not been coded and therefore do not appear on the QOF register.
- (2) **Test results not being acted upon** - CKD patients that have been screened by the practice within the past 15 months but are not yet being treated or coded.
- (3) **Not enough screening** - Patients that have risk factors such as hypertension, CHD, or diabetes that have not been screened for CKD within the past 15 months.

6. EMIS/Vision/SystemOne searches- identification of “missing” patients in clinical systems

Audits are being undertaken in several areas to find the ‘missing’ patients in GP practices’ clinical information systems. Practices were asked to search for ‘missing’ patients which have been segmented into three categories.

The search protocol for practices using EMIS is detailed below:

Albumin/Creatinine ratio (ACR) protocol for EMIS users^{ix}

(Figures in brackets relate to the relevant domain in the QOF)

Search 1- treated but not coded: patients that are NOT on the CKD QOF register and:

- Are on ACE/ARBs (CKD5) and
- Have had an eGFR within the past 15 months to 09/12 (CKD6) and
- Blood pressure reading within past 15 months is <140/85 (CKD3) and

Where relevant the patient ethnicity is used to multiply the eGFR by 1.21 as indicated in the 4 factor MDRD equation.

Search 2 – not treated and not coded: patients that are NOT on the CKD QOF register and have had an eGFR within the past 15 months to 09/12 (CKD6) but:

- Are NOT on ACE/ARBs (CKD5) or
- Blood pressure reading within past 15 months is >140/85 (CKD3) or
- eGFR NOT multiplied by 1.21 for ethnicity if relevant

Search 3 – not investigated for CKD when risk factors present: patients that are NOT on the CKD register and:

- They are on one or more other related register (diabetes, hypertension, CHD) but eGFR is older than 15 months to 09/12 or has never been done

Results of searches undertaken in the Hammersmith and Fulham CCG region were shared with NHS Kidney Care. Significant numbers of patients were identified using the searches. Examples from individual practices include:

- A GP practice with a registered patient list of 8000 revealed 112 patients using Search 1 criteria. Of these, 11 had CKD Stage 3. The practice had 265 patients registered on QOF before the search with an expected number of 370 creating an original prevalence gap of - 28%.
- The same practice identified 174 patients using the Search 3 criteria. Of these 142 have last eGFR>=60. 51 of these have eGFR>90. 12 patients have been identified as getting repeat prescriptions for antihypertensive medication but have not had U+E check or ACR check: letters are being sent out.
- A practice with a registered patient list of less than 4000 identified 88 patients using Search 3 criteria.

7. Collaborative working with nephrology: The primary/ secondary care interface

Each of the Low CKD Prevalence Workshops in London featured a Question and Answer session with a Consultant Nephrologist (see Appendix 1). The sessions provided GPs with a valuable opportunity to discuss actual clinical examples from everyday practice and address issues which had arisen as a result of performing searches for missing patients. Consistent key messages pertaining to the clinical management of CKD patients were presented at each workshop. These included:

Renal Function should be measured annually in patients who fall into the following risk groups

- Known vascular disease
- Heart failure
- Patients on ACE Inhibitors or Ag Receptor Blockers
- Hypertension
- Diabetes
- Recurrent urinary tract infections
- Metabolic disorders leading to recurrent kidney stones
- Neurogenic bladders and patients with surgical urinary diversion
- Patients on long term NSAIDS (>12 months)

The renal service at Imperial College NHS Trust has demonstrated that they are very keen to open a dialogue with the emerging CCGs in North West London to agree a clear pathway of care for patients with CKD .

8. The CKD Low Prevalence workshops

Between November 2012 and January 2013 a further five CKD Low Prevalence workshops were held across London. In addition two CKD study days were held for primary care staff. (See Appendix 1). NHS Kidney Care worked with CCG leads to produce a locally driven, tailored agenda for each event. The workshops were chaired by a local GP and all workshops included a Q&A session with a nephrologist.

NHS Kidney Care encouraged local ownership of the outcomes and actions from the workshops and supported CCGs by organising venues and catering, briefing and supporting chairs, promoting the event to all GP practices locally through emails, mail-outs and via the NHS Kidney Care website, supporting practices to run a pre-event audit of their clinical systems, providing resources including hard copy tailored QOF CKD prevalence data and the NHS Kidney Care CKD Resource Pack for all delegates.^x

In total the events were attended by a total of nearly 230 delegates from across the selected London CCGs, with over 150 GP delegates. Practice nurses and practice managers made up the majority of the non GP delegates.

Delegates were asked to complete an evaluation form at the end of the event and examples of feedback are listed in Appendix 2.

9. Project findings and outcomes

- **The principle finding of the CKD Low Prevalence workshop project is that hundreds more patients have been diagnosed with CKD and are being treated than is thought to be the case using QOF as the indicator.** Why GPs are not coding all of their CKD patients requires discussion and verification at both a strategic CCG and individual practice level. Possible reasons that have been identified include time pressures, not being fully cognisant of which codes to use, not believing that coding is important, feeling that CKD stage 3a is not really a disease and may be only temporary, having large numbers of African / Caribbean patients and not wanting to 'over-diagnose'.

- Through discussion with practices and their leadership teams, it is apparent that the starting point to the 'missing' patients / prevalence gap which should happen but often does not is mainly influenced by GP perceptions and administrative processes. There is likely to be a range of causes. Examples cited by practices included: lack of sufficient clinical knowledge, lack of inclination, time pressures, poor organisational processes or insufficient staffing in practices, and non-compliance from patients.
- GP perception around CKD may be resulting in poor practice organisation and administration processes too. When test results arrive in the practice, unless the GP goes into the patient record, identifies and acknowledges a CKD diagnosis and records that finding appropriately, the results may be ignored and the patient never told of their CKD or placed on appropriate medications. Ideally this is the point at which a GP makes a diagnosis of CKD, staging the disease, and correcting the eGFR to account for ethnic group. A conversation with the patient should take place at this point and relevant prescribing put in place.
- Another area of concern is practice processes around repeat testing which may not be in place and therefore may be occurring at a frequency of less than 15 months. Most patients that have other co-morbidities such as hypertension, CHD, or diabetes are in general offered regular assessments by their practices which would include testing for CKD. In practices where these are absent or too infrequent, there is a risk of undetected disease deterioration which could lead to CKD patients presenting with late stage disease to an acute renal unit.
- There have been some instances, particularly of young patients, who have not had reason to visit their doctors until they were feeling tired and sick from end stage renal failure. They were not known to have the usual risk factors for diabetes high blood pressure etc. This is a reflection of the fact that CKD tends to be asymptomatic until a late stage.
- Low prevalence is likely to be a combination of poor coding (not coding all those whose blood test results would show they have CKD) and under-diagnosis because of under-testing.

9a. Strategies to reduce the CKD prevalence as identified by delegates at the London CCG workshops

The following are examples of suggestions put forward by primary care clinicians, nephrologists and staff during and after the workshops;

- GPs with low recorded prevalence at an individual practice level should be encouraged to run regular searches in order to audit and identify missing patients.
- It is recognised that some GP practices are reluctant to code patients with an eGFR of >60 as this entails additional administration and follow up. CCGs could work with outlying practices to explore their recorded CKD Prevalence from QOF at Stages 3-5.
- There was a suggestion from GPs around incorporating routine U/E and urine dipstick/ACR testing in the NHS Health Check and new patient testing in patients over 40.
- All patients with hypertension should have U/E testing as part of their routine follow up, as per the NICE Hypertension Guidelines which include testing for the presence of protein in the urine by sending a urine sample for estimation of the albumin:creatinine ratio and testing for haematuria using a reagent strip^{xi}.
- Increased ACR testing in patients at risk – metabolic syndrome, hypertension, obesity.

- Sharing searches and using searches/audits built into the clinical systems to improve coding.
- All the above (especially the extra testing) requires and is likely to generate extra work. Therefore this should be followed through with Local Enhanced Services (LES) or network plan to encourage uptake of these measures in primary care
- Diagnosis of CKD should be supported with widely available patient information leaflets, and possibly structured education
- Communication between primary and secondary care needs to be improved:
- There should be clearly agreed referral and staging protocols (current guidelines should be made available for the patch as soon as possible whilst the new ones are agreed).
- Communication with renal consultants should be made very straightforward via email – maybe some guidelines should be developed for these e.g. what data a renal physician would want to see.
- Clear guidance about when patients can be discharged back to primary care, their follow up and criteria for re-referral.
- Discussion has shown that clinical education does still need to be made more robust around:
 - Disease staging
 - Prevention of deterioration to be managed by primary care
 - How to distinguish between a temporary drop in kidney function and long term disease
 - Why it is important to monitor regularly
 - The relationship with cardiovascular disease
 - When to refer to secondary care

9b. Outcomes at an individual CCG and inter CCG level

Feedback has been collated following the workshops that have taken place to date. Of particular note is the evident commitment to address the issue of CKD in the North West London area. Nephrologists from Imperial Hospital have stated a commitment to work across NHS Hounslow, Hammersmith and Fulham, Westminster, Brent and beyond to create a North London CKD Forum, with the objective of modernising and developing the outreach nephrology service to reduce the burden on secondary care and allow CKD patients to receive care closer to home. This may be achieved by the development of clearer guidance about patient movement through the system and agreed referral pathways.

There is commitment to developing practical, locally driven guidance for GPs around how to register patients, who to register, how to conduct accurate searches, screening protocols and patient education resources. Each CCG will identify a named CKD champion and be linked with a named nephrologist. CCGs will review their QOF data, EMIS searches and prevention strategies every six months, as it is recognised that coding and administration are significant factors in the low numbers of recorded patients in some practices. It is highly encouraging to see commitment to sustaining the momentum.

Camden CCG has three GPs who are now CKD locality leads or CKD champions. They have developed searches to identify missing cases. The first stage of their process is to identify patients who have had 2x eGFR readings of <60 who are not registered within QOF. There is commitment to sustained partnership working with Nephrology colleagues at the Royal Free Hospital to expand and develop the virtual clinic. All GPs in Camden will be encouraged to utilise the QKidney Risk Calculator with at risk patients. <http://www.qkidney.org/>

Practices within Hounslow CCG ran an audit to identify patients at CKD stage 2 who have been urine checked but were not coded. Findings indicate that patients who are not correctly coded at present are receiving the relevant treatment. It is acknowledged that this group of patients do not fall within the QOF parameters of CKD Stage 3-5 and therefore will not directly impact upon a reduction in the prevalence gap.

10. Recommendations for GP practices

GP practices are encouraged to:

- Review their practice level CKD QOF prevalence data every 12 months, ideally every 6 months.
- Understand their observed versus expected CKD prevalence and how they compare to neighbouring practices within their CCG.
- Consider the age, ethnicity and deprivation scores for their patient population and how this may impact upon expected CKD prevalence rates.
- Audit for “missing” CKD patients every 6 months using EMIS or similar search protocol.
- Ensure awareness of CKD is maximised amongst all practitioners by attending study sessions or completing e-learning modules.
- Revisit the NICE CKD Guidance and Quality Standards at regular intervals with all clinical staff.
- Encourage CCG locality co-ordinators to facilitate protected CKD learning time events.
- Act as CKD champions for their CCG and work to support neighbouring practices exhibiting low diagnosis rates.
- Actively work in partnership with colleagues in secondary care nephrology services to discuss referral protocols and when how to manage CKD patients discharged from secondary care.
- Access NHS Kidney Care resources around CKD.
- Work with newly emerging Cardiovascular disease (CVD) clinical networks to address low recorded CKD prevalence.

11. Recommendations for Clinical Commissioning Groups (CCGs)

CCGs are encouraged to:

- Form communities of practice or CKD Forums to address the variation of CKD prevalence within and between CCGs.
- Develop and sustain links with secondary care via their main renal unit to share findings and address challenges as a result of CKD QOF audits.
- Identify GPs to act as CKD champions for the CCG, to work with outlying practices and develop links with local renal units.
- Obtain and disseminate NHS Kidney Care CCG profiles to better understand patterns of CKD within the CCG footprint.
- Urge all practices to adopt regular CKD searches of clinical systems routinely.
- Facilitate Protected Learning Time (PLT) events around CKD awareness and management for GPs and practice nurses.

12. Recommendations for renal units

Renal units are encouraged to:

- Make contact with their local CCGs and support identification of a GP who is willing to act as a CKD champion.
- Engage with CCGs and form communities of practice with the aim of improving care for people with chronic kidney disease, both those known and not known to the unit.
- Conduct a “Late Presenters” audit in order to identify any possible patterns in incidence and particular GP practice(s).
- Review the CCG profiles from NHS Kidney Care and understand the variation in prevalence across referring CCGs.
- Support awareness raising and GP education by participating in Protected Learning Time events for GPs and Practice Nurses. CCG locality co-ordinators are a first point of contact for such events.
- Form CKD Forums or networks with CCGs to address issues pertaining to identification, management and referral of patients with CKD.

13. Acknowledgements

Thanks are due to Carol Davies and James Hollinshead from East Midlands Public Health Observatory (EMPHO), who assisted NHS Kidney Care in the observed vs expected CKD prevalence calculations from QOF data, and produced CCG level reports for workshops.

Appendix 1

CKD London workshop details

CCG	Date	Chair	Nephrologist Q&A	Number of GP attendees	Total Number of attendees	Contacts
Pilot Event-Hammersmith	18 th September	Dr Tony Willis, GP, NHS Hammersmith & Fulham CCG	Dr Peter Hill	6	14	tony.willis@nhs.net p.hill@imperial.nhs.uk
Brent	29 th November	Dr Ethie Kong Chair NHS Brent CCG Dr Sarah Basham	Dr Andrew Frankel	15	22	Etheldreda.Kong2@brent-harrowpcts.nhs.uk sarah.basham@nhs.net Andrew.Frankel@imperial.nhs.uk
Hammersmith and Fulham, Westminster	6 th December	Dr Tony Willis	Dr Andrew Frankel	17	25	Tony.willis@nhs.net Andrew.Frankel@imperial.nhs.uk
Hounslow	15 th January	Dr SaqibLatif Hounslow CCG	Dr Peter Hill	12	19	saqiblatif@nhs.net p.hill@imperial@nhs.uk
Tower Hamlets	24 th January	Dr Sam Etherington Dr Sally Hull Reader in Primary Care Queen Mary University of London	Dr Neil Ashman	41	56	ekramul.hoque@nhs.net Neil.Ashman@bartshealth.nhs.uk
Camden	31 st January	Dr Jeremy Sandford	Dr John Connolly	8	13	jeremy.sandford@nhs.net johnconnolly@nhs.net

CKD study sessions

CCG	Date	Number of attendees	Number Of GP attendees
Ealing	20 th November	47	23
Newham, Ealing, Hackney, Tower Hamlets	13 th December	52	37

Appendix 2

Feedback from delegates attending CKD Low Prevalence Workshops

Identifying missing patients

A practice Nurse from Brent CCG noted that 135 CKD patients had been identified after the EMIS search was conducted.

A GP from Hammersmith noted that 50 missing patients at CKD Stage 3 had been identified.

Frequently cited learnings from workshops

“Many patients in secondary care are actually stable and could be better managed in primary care”- Salaried GP.

“Under-reporting is a huge problem and I will look at the coding issue”. – GP

“Sharing information in small groups is always useful and I note that the coding issue isn’t restricted to just my practice”. – GP

“The informal conversations and ability to ask questions to renal consultant was excellent”. – GP

“eGFR is a good indicator of CKD prediction.”- GP.

“The discussion with the Nephrologist was really helpful”. - GP.

How will knowledge and skills be implemented?

“I know what we have to do. I know it is difficult to do and will take and money and resources whilst keeping our doors open to the patients’ agenda”. – GP

“I will run an EMIS search as a matter of priority”. - GP

“I will conduct a search and address coding with my team at the next practice meeting”.-GP

“Will apply to diagnostic criteria better and discuss screening with partners”. - GP

“I will conduct a search and re-code immediately!”- GP

“Will address our CKD management strategy”. – Lead GP.

“I will review my CKD register and make sure I action patients I need to, and review regularly”- GP

“I will screen more young and asymptomatic patients”-GP

Appendix 3

Resources



[Late presenters to a renal clinic – an audit report and toolkit for general practice](#)

Reports the findings of a retrospective study carried out on patients who presented late to a renal service.



[CKD Resource Pack Introduction](#)

An introduction to NHS Kidney Care's Chronic Kidney Disease Resource Pack



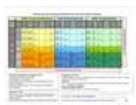
[CKD Screening](#)

Poster summarising the 2008 NICE guidance on CKD Screening



[Interpreting Proteinuria \(ACR\)](#)

Poster summarising the 2008 NICE guidance on Interpreting Proteinuria (ACR)



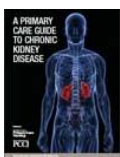
[Follow Up and Coding for CKD](#)

Wall chart on follow up and coding for CKD developed by GP Dr Michael Gordon to help simplify the management of CKD in primary care.



[Albumin: Creatinine Assessment in CKD and Diabetes](#)

Wall chart on proteinuria workup developed by GP Dr Michael Gordon to help simplify the management of CKD in primary care.



[Primary Care Guide to Chronic Kidney Disease](#)

A special issue of the British Journal of Primary Care Nursing (BJPCN), this looks at the functions of the kidney and the causes and risk factors of CKD, and how the care of patients can be improved.



[Kidney disease: key facts and figures](#)

Outlines basic facts about kidney disease in England, including how common it is, what makes people at risk, and the associated costs.



[Diabetes with kidney disease: Key facts](#)

Provides facts about diabetes with kidney disease, including how common it is and what puts people at risk, as well as what can be done and the cost-effectiveness of different interventions.



[How-to guide - ACR protocol](#)

A protocol for the EMIS Web patient record software is helping GPs to interpret and take appropriate action on albumin/creatinine ratio (ACR) results, improving the detection and early management of chronic kidney disease (CKD).

Commissioning resources:



[Health Inequalities and Chronic Kidney Disease in Adults](#)

Highlights the inequalities that exist in CKD between people of different backgrounds, ethnicity and age. It summarises the current evidence base, looking at the prevalence of CKD, key risk factors, access to renal replacement therapy (RRT), and access to transplantation.



[CKD PCT profiles](#)

One profile for each of the 152 Primary Care Trusts, these are designed to help commissioners and healthcare providers assess local kidney care need and current service levels.



[CKD Quality and Outcomes Framework \(QOF\) toolkit](#)

Provides a number of measures to support the delivery of kidney services, including reported and expected CKD prevalence, and performance against the QOF indicators.



[Commissioning CKD Resources Guide](#)

A collection of useful links to resources relevant to clinical commission groups.

References

ⁱQuality and Outcomes Framework CKD Data 2011-12.

<https://mqi.ic.nhs.uk/Search.aspx?query=qof%25ckd%251&ref=1.05.2>

ⁱⁱA mandate from the government to the NHS Commissioning Board. Department of Health, 2012.

<http://mandate.dh.gov.uk/>

ⁱⁱⁱ The NHS Outcomes Framework 2012/13 Department of Health

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^{iv} Cardiovascular Disease Outcomes Strategy. Department of Health, 2013

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^vFor more information on HSE methods and results see: <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england>.

^{vi}NHS Kidney Care “Health Inequalities and Chronic Kidney Disease in Adults”. 2011

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