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Improving the management of chronic kidney disease (CKD) in primary care

Teams from the Greater Manchester Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and Leicester, Northamptonshire and Rutland CLAHRC have been working together to produce audit and support tools to improve care for patients with CKD.

"The support tools have enabled practices to achieve their objectives with much more efficiency than those working without the tools."

Finding the missing cases of CKD

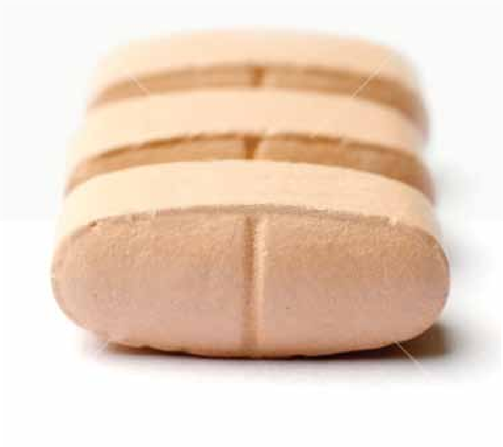
CKD is common affecting around 5-10 per cent of the adult population, and is a disease area that has been included in the Quality Outcomes Framework (QOF) since 2006/07.

NICE developed guidelines for CKD in 2008 which aimed to promote earlier detection, intervention and prevention or delay of complications including end stage kidney disease.

Despite this, research findings and QOF data indicates that there is a gap between recorded and estimated prevalence and that around 30 per cent of those patients who receive a diagnosis are not receiving adequate care.

The two CLAHRC teams set out to address this by developing audit tools and resources to help practices improve CKD care.

Each of the organisations had their own project objectives. For example, the team in Manchester aimed to halve the gap between expected and recorded prevalence of CKD in each local practice, and ensure that at least 75 per cent of patients on the CKD register are tested for proteinuria.



Working in partnership

The Greater Manchester team developed a guide that provided practices, and practice nurses in particular, with advice on the effective ways to improve CKD care - based on NICE guidance.

The Leicester team developed a comprehensive audit tool that enabled practices to quickly and efficiently identify undiagnosed patients, incorrectly diagnosed patients and patients at high risk of developing CKD, or of quicker progression in existing patients.

This audit tool also provided practices with information on how well they were managing the care of their patients, helping them to target improvements where it was needed most.

These two resources have both been effective individually as implementation tools and both CLAHRC organisations believe that the benefits of each could be maximised by combining them into a single package for more widespread improvement capacity. They are currently developing a package for this purpose and refining the resources in order to make them available to a wider audience.

Use audit results to track patients

Practices in Greater Manchester were helped to use the audit results to create 'trackers' – lists of potential and already diagnosed patients on which they could record their actions for each one.

The practices worked through these trackers in a structured way, often splitting the lists to divide responsibility for the actions amongst the team without the risk of duplication.

Practices then submit data to the Greater Manchester CLAHRC team each month and the results from the audit tool are also used to evaluate progress.

Phase two of the CKD Improvement project has been a real success with 539 previously undiagnosed patients identified.

A total of 95 per cent of patients have been tested for proteinuria, and 83 per cent of patients are achieving NICE-recommended blood pressure targets.

Practices have also been able to remove a number of patients who were mistakenly added to CKD registers in the past. This efficiency saving has enabled some practices to take on additional work, such as training in motivational interviewing and evaluation of a new self-management guidebook developed by one of the GM CLAHRC's research teams.

Contact: Brook Butler
Knowledge Transfer Associate
NIHR CLAHRC for Greater Manchester
Email: brook.butler@srft.nhs.uk
Telephone: 07703747091