

HIN 2024 Cardiometabolic Fellowship – Chronic Kidney Disease QI Project Guidance

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SMART aims for CKD Detection, Monitoring And Optimisation Projects

CKD projects may look at case finding, re-coding, treatment optimisation or process redesign of CKD. CKD SNOMED codes should now be changed to include both the blood (eGFR) and urine (ACR) values relevant to CKD detection use group 1 coding rather than group 2. This presents an opportunity to send patients for renal function testing and then re-code them.

CKD management slows the progression toward renal failure and prevents cardiovascular related sequelae of CKD, by optimising blood pressure, cholesterol and diabetes control. Sample project aims might be:

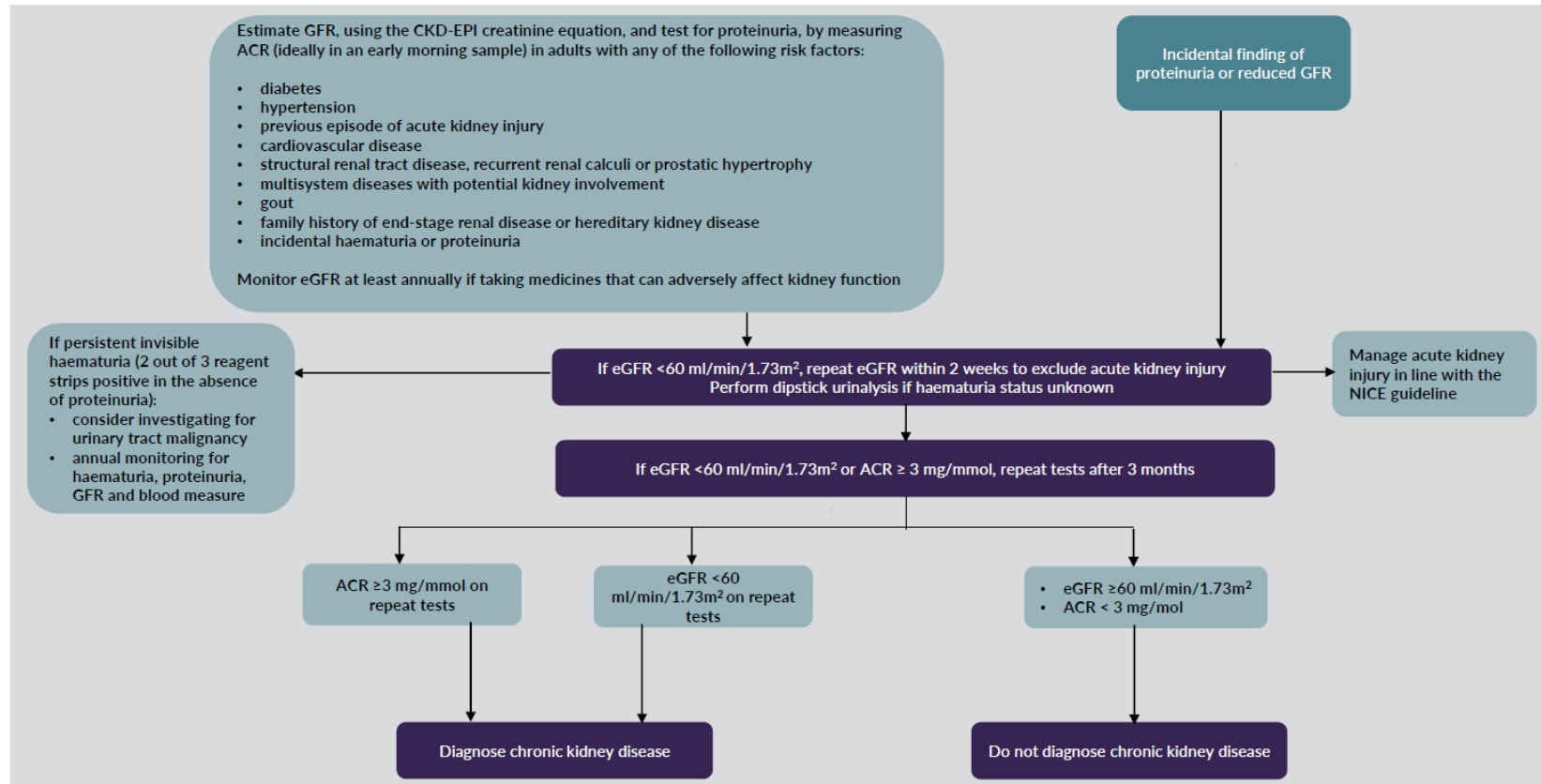
- Search for OLD SNOMED CKD coded patients, check patients urinary ACR and GFR – re-code as appropriate.
 - SMART aim: *To re-code 20% of CKD patients by November 2024 based on up-to-date eGFR and urinary ACR.*
- Up titrate ACE inhibitors / ARBs to maximum tolerated dose
 - SMART aim: *To review 20 CKD patients and optimise treatment (ie to up titrate their ACEi or ARB to the maximum tolerated dose) by October 2024*
- Find patients at risk of CKD and send for testing
 - SMART aim: *Review 100 patients with a history of hypertension and diabetes who are not coded for CKD and send them for urinary ACR and eGFR by December 2024.*
- Offer SGLT2 inhibitors to eligible patients
 - SMART aim: *Offer 50 appropriate CKD patients SGLT2i and monitor with follow up by November 2024.*

A SMART Aim is Specific, Measurable, Achievable, Relevant, & Timebound

NICE Guide To Identifying CKD In Adults – [Link Here](#)

Identifying chronic kidney disease in adults

NICE National Institute for Health and Care Excellence



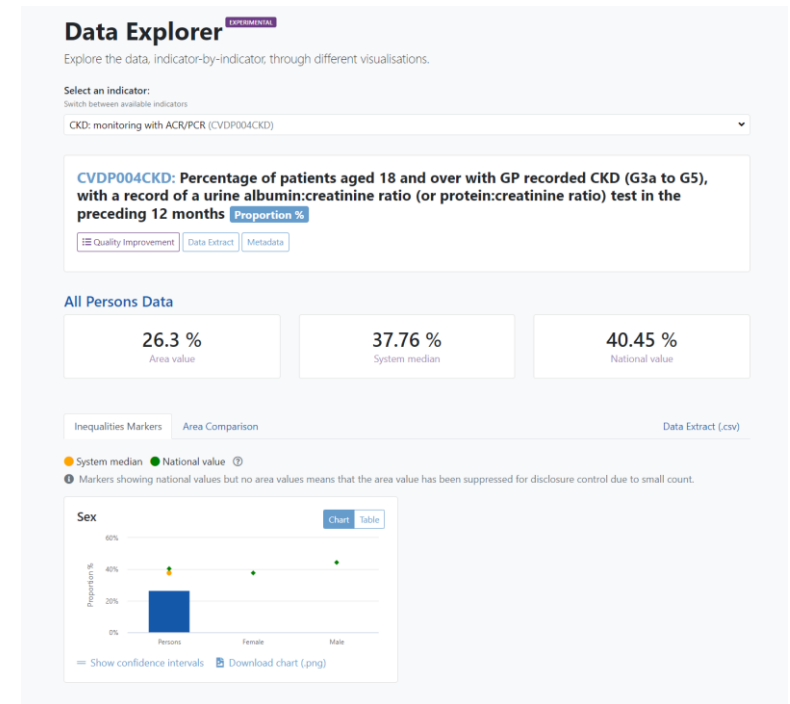
CVDPrevent - CKD Data



[CVDPrevent](#) is a national audit of GP records to support primary care in understanding how many people with cardiovascular disease (CVD), or conditions that lead to a higher risk of developing CVD, are potentially undiagnosed, under treated or over treated. The metrics used relating to CKD are:

- CKD: uncoded case finder (CVDP002CKD)
- CKD: high risk case finder (CVDP003CKD)
- CKD: monitoring with ACR/PCR (CVDP004CKD)
- CKD: recorded eGFR (CVDP006CKD)
- CKD: treatment with renin-angiotensin system antagonists (CVDP005CKD)
- CKD: ACR less than 70mg/mmol with BP to target (CVDP007CKD)

To access these, go to [CVDPrevent](#) then select 'Data Explorer' and find your practice or PCN.



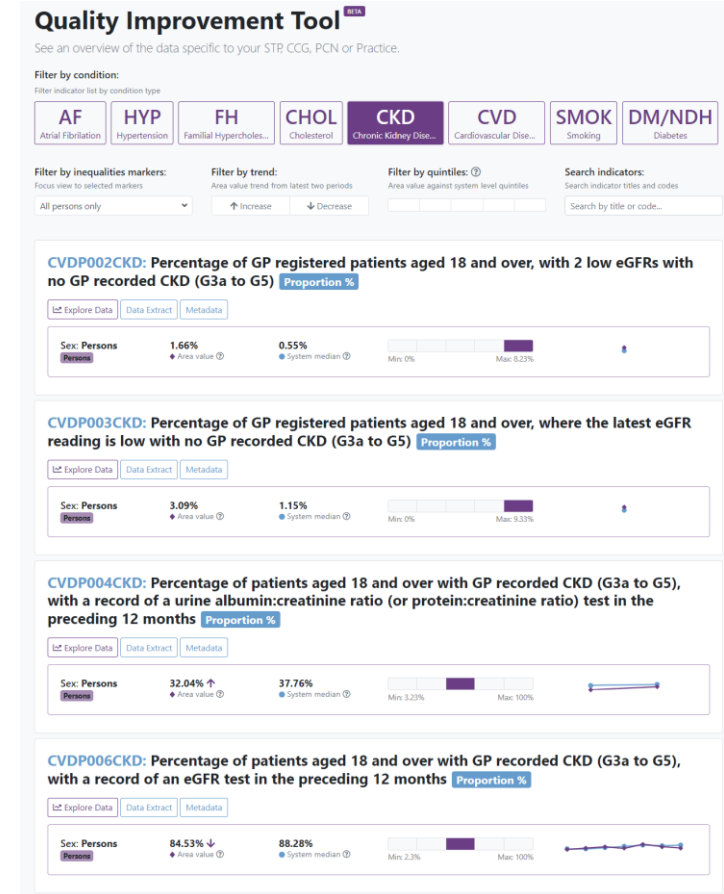
CVDPrevent – Quality Improvement Tool



The metrics used relating to CKD are:

- % of patients with recorded CKD
- % of patients with evidence of CKD in medical record but not present on CKD register (uncoded CKD)
- % people on CKD register with an uACR test in last 12 months
- % people on CKD register with an eGFR test in last 12 months
- % people on CKD register with an ACR of less than 70 mg/mmol with controlled blood pressure
- % people on CKD register with HTN and proteinuria who are currently treated with RASi
- % people on CKD register with a previous prescription for lipid lowering therapy

To access these, go to [CVDPREVENT](#) then select 'Quality Improvement Tool' and find your practice or PCN.



CDRC Searches

Clinical Digital Resource Collaborative has Population Reporting Searches available to support the identification and management of patients with un-coded / coded CKD.

These searches are available for [EMIS](#) or [SystemOne](#)

You can find a guide on how to download and use the searches [here](#). As well as video guidance [here](#) and [here](#).

Please note for SystemOne – you may need to request access by following [this guide](#).

6

The screenshot shows the top section of the CDRC website. At the top left, there is a logo for 'Clinical Digital Resource Collaborative' with the tagline 'CDRC Supporting Clinical Decisions'. Next to it is a green arrow pointing right with the text 'Join our Journey' and 'North East and North Cumbria'. To the right is the NHS logo. Below these is a search bar with a magnifying glass icon. A blue navigation bar contains the following links: Home, About Us, The Team, Resources, FAQs, News and Events, and Contact us. Below the navigation bar, the breadcrumb trail reads: 'You are here: [Home](#) / [Resources](#) / [EMIS Resource Centre](#) / [EMIS Specialties](#) / [EMIS Renal Overview](#) / EMIS: Chronic Kidney Disease (CKD)'. The main heading is 'EMIS: Chronic Kidney Disease (CKD)'. Below the heading, a sub-heading states: 'CDRC has Population Reporting Searches available to support the identification and management of patients with un-coded / coded CKD.' At the bottom, there are two teal buttons with white text: '▶ Accessing the CKD Population Reporting Searches' and '▶ Guidance on the CKD Population Reporting Searches'.

CDRC Searches

- Clinical Digital Resource Collaborative searches for CKD cover a large variety of searches which may be relevant to your chosen area. They are split into three themes; case finding, management and intervention prioritisation. Some examples of the searches are:
 - CKD Case finding
 - ? CKD 2.0 Casefinding – All patients with potentially uncoded CKD - *Patients not coded with CKD, with diabetic kidney disease* **OR** two ACR ≥ 3 **OR** two eGFR < 60 .
 - ? CKD 2.10 Casefinding – All patients with possible CKD – need repeat eGFR or ACR - *Patients not coded with CKD with an isolated eGFR < 60 or an isolated ACR ≥ 3 .*
 - ? CKD 2.11 Casefinding – eGFR < 60 (isolated) over 4 months ago but not coded with CKD 3-5 – Repeat U+E - *Patients not coded with CKD 3-5 but who's last eGFR was < 60 (at least 4 months ago).*
 - CKD Management
 - ? CKD 3.12 – BP Management – BP not controlled
 - ? CKD 3.31 – Lipids Monitoring –
 - CKD Intervention Prioritisation
 - ? CKD 4.1 – CKD Intervention Prioritisation – Highest priority
 - ? CKD 4.2 – CKD Intervention Prioritisation – High priority
 - ? CKD 4.3 – CKD Intervention Prioritisation – Lower priority

CKD Projects – Ideas for Delivery

Following are ideas for delivery to get you started in planning your project. Your project will need to reflect ways of working in your practice, staff and patient need, and any other factors – but this can help you get started.

CKD Coding Sample Project

To implement a project relating to CKD coding you may:

1. Construct a process map of how you would proceed with searching for the patients, contacting them, sending them for testing and then discussing the results with them. Refer to local and national guidelines.
2. Identify stakeholders and invite them to co-design the process with you, this may include administration staff and other clinicians. Engage patient representatives to help you co-design the patient facing aspects, such as communications and the patient journey.
3. Use a search to identify how many patients are coded as CKD to create your baseline group.
4. Chose a manageable amount of this group to focus on for the first PDSA cycle. Review their healthcare records, remove any patients who appear to have been coded incorrectly.
5. Identify patients who have had recent eGFR and uACR tests – identify the appropriate new code and re-code patient.
6. Invite those who do not have all the up-to-date test results for further testing. Record the number of invites you send.
7. Review the results and notify patients of normal results, invite the others to have their condition reviewed with their clinician.
8. Re-code these patients as appropriate and record the outcome.
9. Review the process - what worked well, what didn't?
10. Implements another PDSA cycle with the next group using learning from the first group, perhaps different approaches to contacting them or timelines for the discussion.

CKD Medication Optimisation Sample Project

To implement a medication optimisation project you might:

1. Engage with relevant staff (administrative and clinical) as well as patient representatives to co-design a process map.
2. Discuss with prescribers the required appointment length and factors which may make a patient more complex.
3. Search for patients coded for CKD in a target group ie:
 1. Not prescribed a statin and have not previously declined.
 2. Not currently prescribed an ARB or ACE inhibitor and have not previously declined.
 3. Prescribed a low dose of ARB or ACEi and have not previously declined.
 4. Are on an ARB or ACEi but and may be suitable for a SGLT2 inhibitor and have not previously declined.
4. Invite a set number of these patients for review based upon what is achievable in the time frame
5. Discuss their medications and make changes where appropriate. Prepare FAQs and patient information leaflets to provide to the patient.
6. Review what worked well, what didn't? Make changes to the process map.
7. Repeat PDSA cycles working through your decided cohort.

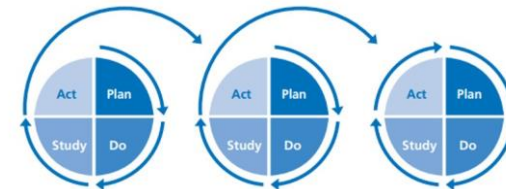
CKD Case Finding Sample Project

A project plan to identify new cases of CKD could involve:

1. Draft a process map, engaging others who may be involved in the process, such as administration staff and other clinicians. Refer to local and national guidelines.
2. Engage patient representatives to create communication materials and develop a patient journey, including required support and education information.
3. Undertake a search for patients who may have CKD but are not coded, such as:
 - Hx hypertension AND diabetes WITHOUT history of CKD. Consider patients who have uncontrolled hypertension and diabetes.
 - Previous low eGFR result without a code for CKD
4. Select a set number of these patients based upon what is achievable in the time frame and review their notes and refer appropriately for review or testing. These reviews could coincide with their regular reviews.
5. Communicate with patients regarding their results and manage appropriately, refer to [shared decision-making tools](#), and local guidelines.
6. Review this cycle, what worked well, what didn't?
7. Start another cycle, with any changes that were required, with the next group of patients.

CKD Process Improvement Sample Project

1. Refer to local and national guidelines and identify any areas which may be different to your practice processes.
2. Engage with relevant staff, administrative and clinical, to identify the ideal process for identifying and managing CKD in your practice
3. This may focus on:
 1. when is best to collect urine samples
 2. how long and how frequent appointments are
 3. best timing to start statins, antihypertensives or SGLT-2i (as appropriate).
4. Engage with patient representatives to co-design a process map which looks at the journey of a patient from diagnosis through management to living with CKD
5. Implement your new process
6. Review the process and identify what works well? What doesn't?
7. Survey staff and/or patients about their experience and gather their feedback, where there any issues? Components they found difficult?
8. Co-design any changes with patients and staff
9. Implement the new process and continue with PDSA cycles as required.



CKD resources to support your project

- Fellowship [Data Dashboard](#)
- Clinical Digital Resource Collaborative (CDRC) **CKD Searches** for [EMIS](#) or [SystemOne](#)
- NICE Guidance: [CKD Assessment and Management](#) and [Identifying CKD in Adults](#)
- NICE Resources: [KFRE Calculator and other tools](#)
- London Kidney Network: [CKD in Primary Care](#)
- SWL ICB: [Investigation and Management of CKD in Adults in Primary Care](#)
- CESEL: [CKD Guide for SEL Primary Care \(Adult\)](#)

CKD resources for patients

- Kidney Care UK: [Chronic Kidney Disease Information](#) and [Kidney Failure Information](#)
- Kidney Failure Risk: [5 Year risk of requiring renal replacement therapy \(stages 3-5\)](#)
- Think Kidneys: [Patient Information Leaflets](#)
- Patient Info: [Chronic Kidney Disease](#)

 Please get in touch – hin.cvd@nhs.net



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