

Innovation Project Response to Questions

Salford Innovation and Improvement Fund Locality Call 2022/2023

1) *There is significant concern over current capacity in primary care - what engagement is already secured, and how many practices will you need to get the evidence required to evaluate?*

Primary care engagement is integral to the successful implementation of the innovative CKD dashboard. A project steering committee will be established which will include representation from primary care. We have already engaged with the Salford IPC Long-Term Condition Lead and the Salford ICP CCIO. We recognise the impact of workforce challenges in primary care and as a result we have incorporated estimated primary care resource within the application as described in response to Question 4.

We will use quality improvement methodology to undertake a stepwise approach to the programme and test various implementation strategies within one neighbourhood to start with. The steering committee will oversee budget allocation and extend to additional neighbourhoods subject to results seen in the first neighbourhood. A health economic evaluation as well as the impact on primary and secondary care capacity will be established. We hypothesise that this project will reduce workload in primary care but is likely to increase workload in secondary care. The ability to deliver this additional workload within secondary care will be mitigated by using our digital innovation (CKD dashboard) rather than traditional outpatient models of care delivery.

Evaluation of the project will be undertaken in partnership with the NIHR Applied Research Collaboration Greater Manchester (ARC-GM).

2) *Scale of the opportunity/benefits - how many Salford patients do we think we would be able to manage better?*

The CKD dashboard has identified 11546 adult patients (4.4% of the total adult population in Salford city) who have either a coded CKD diagnosis, a measured eGFR < 60 ml/min/1.73 m², or a measured albumin-creatinine ratio > 3 mg/mmol.

The Kidney Failure Risk Equation (KFRE) score was calculated for people that had an eGFR and urine ACR available. Updated National Institute for Health and Care Excellence (NICE) guidelines¹ recommend referral to renal services (where appropriate) in patients who are a high risk with a KFRE score > 5% at 5 years. There were 94 (0.97%) patients with a KFRE > 5%. Utilisation of the dashboard enables these patients to be automatically referred into renal services if the project team agree this is an appropriate pathway. This has the potential to identify high risk patients and reduce workload for primary care by creating a mechanism for identification and specialist review.

Perhaps more importantly, the dashboard can also be used to identify patients who are at moderate risk and who will benefit from evidenced based therapies earlier in the course of their disease. This in turn reduces risk of progressive CKD but also reduces cardiovascular event rates. Patients with diabetes are particularly at risk. The dashboard has the potential to identify adult patients with

¹ The National Institute for Health and Care Excellence N. Chronic kidney disease: assessment and management NICE guideline. 2021. Accessed at <https://www.nice.org.uk/guidance/qs5>

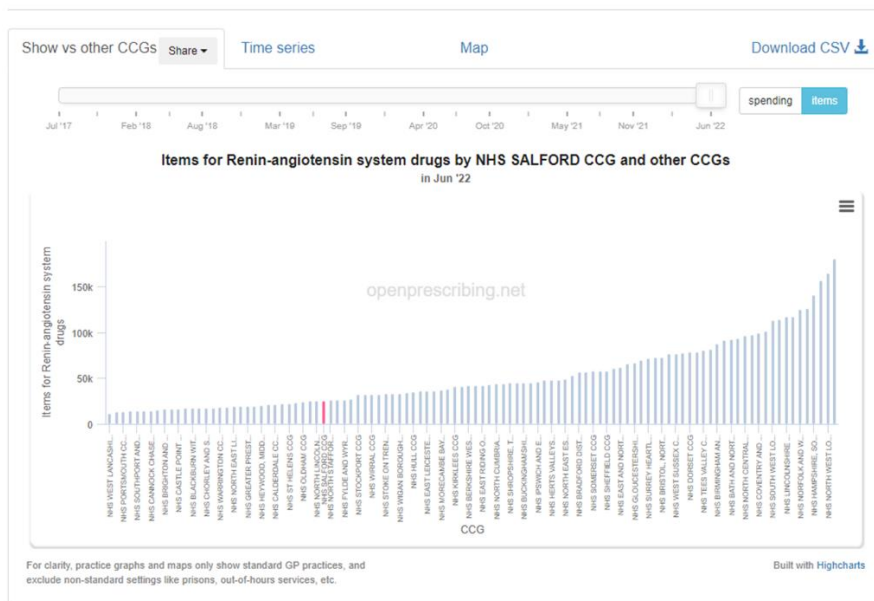
T2DM and evidence of nephropathy. It is estimated that approximately 25% of patients with diabetes have an eGFR <60 ml/min, albuminuria, or both². Estimated diabetes prevalence is 7.9% of the Salford population and is predicted to account for approximately 16,247 patients.³ We can therefore expect that approximately 4000 patients have diabetic kidney disease. The CKD dashboard will enable us to identify patients who may not be receiving optimal therapy.

Use of key medications for the whole CKD dashboard population was as follow:

- renin-angiotensin-aldosterone (RAAS) blockade - 63.6%
- SGLT2 inhibitors - 19.8%
- Statins - 81.4%

NICE NG 203 guidance recommends that patients with CKD should be on RAAS blockade and SGLT2i inhibitors (if urine ACR >22.6 mg/mmol). Salford IPC data¹, indicates opportunities for improved prescribing of reno-protective agents compared to other areas (Figure 1). These data suggest there are opportunities to optimise care in comparison to other areas.

Figure 1A Prescribing data for RAAS inhibitors⁴

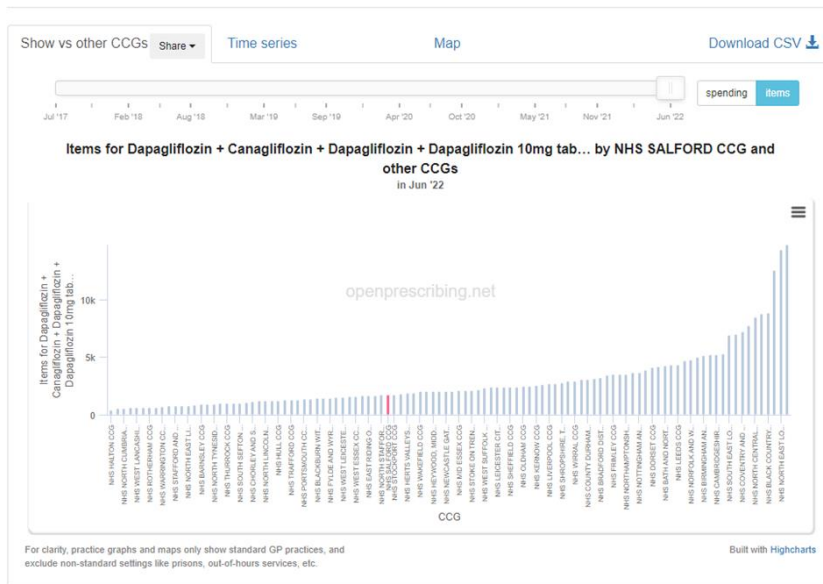


² Hill CJ, Cardwell CR, Patterson CC, et al. Chronic kidney disease and diabetes in the national health service: a cross-sectional survey of the U.K. national diabetes audit. *Diabet Med.* 2014 Apr;31(4):448-54

³ Public Health England. Diabetes prevalence estimates for local populations. Accessed at: <https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations>

⁴ OpenPrescribing.net, Bennett Institute for Applied Data Science, University of Oxford, 2022 Search accessed 14/9/22: <https://openprescribing.net/analyse/#org=CCG&orgIds=01G&numIds=0601023AG,0601023AM,0601023AGAA,0601023AGAAABAB&denom=nothing&selectedTab=map>

Figure 1B Prescribing data for NICE recommended SGLT2i



3) Can we have more detail on the primary care involvement expected and how this will be sought/resourced?

Steering committee

The innovation project steering committee will establish agreed protocols for optimisation of patients at medium risk. This may incorporate virtual CKD reviews or the programme steering committee may recommend testing alternative thresholds which may lead to early specialist-initiated review. Primary care engagement will be key to testing and establishing these thresholds. For example, the steering committee may recommend remote review (via the dashboard) or all patients with medium risk who are NOT on NICE recommended therapy. The project team may feel that this can be delivered by secondary care using virtual reviews, thereby reducing workload for primary care whilst providing specialist input. The project will enable interventions to be evaluated from health economic perspective. We hypothesise that integrated care will improve access to optimal care and reduce costs associated with sub-optimal CKD care as outlined by NHS RightCare.⁵

Virtual MDT

Salford ICP and Salford Renal Services have experience of delivering successful educational outreach for AKI.⁶ We recognised these sessions required engagement from primary care. Improvements in response times to AKI events was noted. The AKI project only required 1 session per practice. We propose a neighbourhood approach which combines virtual CKD reviews in combination with

⁵ NHS RightCare scenario: The variation between sub-optimal and optimal pathways. Accessed at <https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2018/02/abduls-story-progressive-chronic-kidney-disease-full-narrative-1.pdf>

⁶ Tollitt J, Flanagan E, McCorkindale S, Glynn-Atkins S, Emmett L, Darby D, Ritchie J, Bennett B, Sinha S, Poulidakos D. Improved management of acute kidney injury in primary care using e-alerts and an educational outreach programme. *Fam Pract.* 2018;35(6): 684 - 689

educational outreach may be more effective. We have allocated budget to fund practices to engage with virtual MDTs as outlined in response to Question 4.

4) *There is £60k allocated to "primary care engagement" which is a significant amount of money, but it is not entirely clear what this will be spent on, or how it can be determined that this figure is sufficient/too high/too low*

We recognise the importance of primary care engagement from a leadership as well as delivery perspective. Costings for steering committee engagement has been calculated by our Research & Innovation based on similar projects. The costs for delivery have been calculated from our experience delivering AKI educational outreach and discussion with colleagues.

We have allocated some resource to support additional educational activities to increase awareness of CKD within the primary care workforce including AHPs. This provides the steering committee with the opportunity to test a range of interventions across different settings.

Steering committee costs

We would like to fund a GP to co-chair the steering committee and support implementation of the dashboard and provide guidance on wider CKD engagement within primary care. We believe this is essential to the success of the project. We have costed two hours per week of time for a GP to co-chair the steering committee. Based on an hourly rate of £96 (NIHR standard medical rate), this will be **£9,984**.

Primary Care delivery

We have also funded 2 hours per month of CKD champion time per practice to support improvement in CKD care across Salford ICP and suggest that this could be a member of the multidisciplinary practice team, such as a pharmacist or practice nurse. Based on an hourly rate of £42 (NIHR standard non-medical rate), this will be **£42,336**.

Virtual CKD MDTs – we propose 4 virtual MDTs per practice within 1 neighbourhood over a 12-month period. Each MDT will last 1 hour and include relevant case studies. The structure of these virtual MDTs will require input from the appointed primary care lead.

Additional educational resource – £7,500 to support specific training sessions and educational resources.

Total £59,820