Executive Summary of the Findings from a Consultation Exercise about Current Primary Care Priorities for Kidney Health in Greater Manchester

A National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Greater Manchester report

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Executive Summary

Introduction

This executive summary reports findings from a kidney health consultation exercise carried out across Greater Manchester primary care settings between March – June 2015.

What was the aim of the consultation exercise?

This exercise was delivered by CLAHRC GM on behalf of GM AHSN to engage with key stakeholders and general practitioners (GPs) across all Clinical Commissioning Groups (CCGs) in Greater Manchester and Eastern Cheshire (covering the entire GM AHSN footprint) in order to:

1) Understand their priorities around kidney health and other cardiovascular related conditions;
2) Identify the support needed to implement these priorities;
3) Inform the development of improvement interventions in these CCGs.

How was the consultation exercise conducted?

We conducted 45 interviews across all 13 CCGs in Greater Manchester and Eastern Cheshire. Our respondents included CCG leads (23 interviews) as well as GPs without an executive role in their CCGs (22 interviews).

What did we find?

1) There were some areas with a strong interest in kidney health, but the majority of respondents did not see kidney health as their top priority.
2) Kidney health was often seen as part of a broader priority to implement a holistic approach to the management of cardiovascular diseases (CVDs) and long-term conditions (LTCs).
3) Following the introduction of new national policies and guidelines, there is a growing interest in acute kidney injury (AKI) in some of the areas, particularly at the CCG level, but GP awareness of this condition remains relatively low at present.
4) Removal of three of the four chronic kidney disease (CKD) indicators from the Quality and Outcomes Framework (QOF) from April 2015 onwards was seen as a barrier to the successful implementation of CKD-related improvement interventions, particularly by non-executive GPs.
5) Other specific challenges to the roll-out of CKD-related interventions include the continued lack of knowledge around CKD, lack of consensus about its status as a disease, its asymptomatic nature, low patient compliance with attendance for reviews and taking medication, and lack of clinical champions to drive this work forward.
6) There is a significant diversity across different CCG areas in relation to the priorities identified. The most common trends include:

a) Shifting from a disease-specific focus towards an integrated, holistic approach to managing CVDs/LTCs (such as diabetes, chronic obstructive pulmonary disease (COPD), asthma, heart failure and stroke);
b) A growing interest in service redesign aimed at improving patient access and integration with secondary care;
c) Setting priorities in response to the demographic characteristics and healthcare needs of local populations.

7) The following drivers for priority setting were identified:
   a) QOF and other financial incentives (perceived as the most important factor);
   b) Population health data (the gap between recorded and estimated prevalence);
   c) Clinical interests of key stakeholders;
   d) Benchmarking of CCGs and practices against quality targets;
   e) National priorities (reducing hospital admissions and cutting costs).
8) A broad range of needs was identified in relation to future improvement work:
   a) Provision of resources (e.g. funding for additional staff or designing patient identification tools);
   b) Supporting the implementation and evaluation of ongoing improvement programmes (especially outcome evaluations);
   c) Education and training (around various aspects of kidney health, NICE guidance updates and quality improvement in general);
   d) IT support (extracting data for the QOF and other performance monitoring purposes; populating multiple templates; identifying and managing patients; updating IT systems in the light of the new QOF contract and NICE guidance);
   e) Achieving better integration with secondary care and other local services.

What are the implications?

1) Given the diversity of views and contexts, no single improvement intervention is likely to be accepted with equal enthusiasm by all CCGs and/or practices.
2) Reframing kidney health interventions as part of broader CVD/LTC agenda may increase their uptake.
3) Improvement interventions are more likely to be prioritised by commissioners when:
   a) Aligned with the QOF or local incentivisation programmes;
   b) Driven by local clinical champions;
   c) Supported by data demonstrating their relatively quick impact on performance or patient care outcomes;
   d) Seen as relevant for local populations;
   e) Linked with existing strategic plans adopted by the CCGs.

The full report is available at http://clahrc-gm.nihr.ac.uk/our-work/primary-care/kidney-health/ahsn-kidney-health/4/