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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1. Executive Summary

1.1. Introduction

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

1.2. 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.

1.3. 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).

1.4. 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.

1.5. 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 if they are:
   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.

2. Introduction

2.1. Aim

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 understand their current and future priorities for kidney health in the primary care setting.

2.2. Background

This consultation exercise was designed to inform our knowledge about the extent to which kidney health forms a priority within primary care, and to understand more about what aspects of kidney health care stakeholders are focused on at present and what support is needed moving forwards.

Changes in national policies/information available for kidney care over the last 15 years are summarised below (Table 1) to contextualise the discussions held.

Table 1. Recent policy changes in kidney health

2002	KDIGO definition and classification of CKD published in the United States
2006	Awareness of chronic kidney disease (CKD) in UK primary care was stimulated by its entry onto the Quality and Outcomes Framework (QOF)
2008	NICE CKD guidelines first released in 2008 to support implementation of evidence-based care for the condition
2012	KDIGO CKD update and AKI guidelines published
2013	NICE guidelines for acute kidney injury (AKI) were released in August 2013 (CG169), bringing it onto the agenda for primary care
2014	The NICE CKD guidelines were updated in July 2014 (CG182)
2015	Of the four CKD-specific QOF indicators on the primary care contract, three were retired from April 2015. Practices are now only asked to maintain a register of CKD patients. Although the CKD-specific management requirements on QOF have been removed, patients with other comorbidities (such as hypertension or diabetes) may receive the same care under other remaining indicators.

We also reviewed the strategic plans of each CCG as part of this process, in order to identify kidney health priorities at present and over the coming years (report delivered February, 2015). This included focusing on CVD, to identify reference to kidney health over and above that included in the Cardiovascular Outcomes Strategy. We make reference to this strategic plan review in this document, comparing interview responses to written strategic five year plans.

In areas where kidney health hasn't been identified as a priority to date; some questions were refocused on broader areas of healthcare/improvements to maximise learning. Consequently, CLAHRC GM and GM AHSN will be able to understand more about:

1) The viability of kidney health focused improvement initiatives;
2) Other potential areas of interest where interventions/improvement work may be welcomed;
3) How any intervention/support could be tailored to meet current needs.

2.3. Approach

As an initial step, we analysed the content of relevant strategic plans from each CCG, with a focus on CVD and kidney health.

The approach to engage stakeholders varied per CCG dependant on pre-existing relationships from previous collaborative working. Ascertaining the necessary targeted contact details, initial engagement, and developing relationships formed a large part of the early project work.

Once leads from each CCG had been made aware of the consultation, we then initiated contact at practice level. Five practices were initially selected per CCG by the CLAHRC GM team to gain a representative sample of the region as a whole. Practices were carefully selected to provide a broad range of practice list sizes; remote and inner-city practices; varied socio-demographic representation; and a mix of those whom CLAHRC GM had worked with previously and not. However, the invitation: reply ratio was very low initially; therefore we extended invitations significantly (see Appendix A) and subsequently targeted GPs with a particular interest in long-term conditions care. Where possible we conducted interviews in person (in order to build a rapport with the interviewee). However, some interviewees requested a telephone interview.

2.4. Questionnaire development

In order to gather the necessary data, two sets of interview questions were developed (one for CCG leads, the other for GPs). The variation accounted for the expectation that CCG stakeholders would have a more strategic outlook on kidney health policy; and that GPs may identify more operational issues and challenges concerned with delivering kidney care at the frontline. However, both sets of questions covered the same broad themes, and some of the questions were identical (see Appendix B).

The interviews conducted were semi-structured in nature, to allow interviewers to explore areas of interest from responses that interviewees gave. The questions were refined after initial interviews; improving the flow of delivery, reducing the length of the interviews, and to avoid duplication of responses.

2.5. Engagement

Overall, 45 interviews were conducted (refer to Appendix A for details), of which 23 were with CCG leads, from all 13 CCGs. It should be noted that 12 of 23 the CCG interviewees were also practicing GPs. Of 156 practices contacted, 22 GPs (who did not have a role within the CCG) agreed to be interviewed. Somewhat poorer uptake was achieved than expected from practices, possibly partly influenced by project timing (clashing with end of year QOF work).

2.6. Data analysis

Emerging data was summarised and discussed throughout the course of the project. Combined CCG and practice views are presented (unless otherwise stated) as responses from both sides often showed commonality. Therefore, a thematic analysis of both sets of interview data was performed to draw out key themes, and explore commonalities and differences between them. Views of individuals (1 or 2 participants) have been excluded unless of particular note.

Quotes have been provided to substantiate points of interest. These have been coded for anonymisation, and to demonstrate whether they were provided by a stakeholder within a CCG role (e.g. CCG17) or non-executive practice-based interviewee (e.g. PRA5).

3. Findings

Three broad themes have emerged from the data:

i) Kidney health priorities
ii) Broader priorities
iii) Support needed

In the following sections, the main views are reported. The data from CCGs leads and GPs are combined (unless otherwise stated). Where appropriate, we have included anonymised quotes to illustrate key points.

3.1. Kidney health priorities

The first section of the interviews explored the current priorities for kidney health care and how these decisions were made. Questions were asked to gauge how aware people were about recent changes to associated guidelines and national policy (refer to Table 1), so that we could understand how people had responded to such developments, and what enablers and barriers were present that would affect the adoption of evidence-based practice or an intervention to facilitate this process.

3.1.1. Kidney health care current status

Although it was acknowledged that variation in kidney health care exists between different CCGS as well as individual practices, responses suggest the standard of kidney care provided to patients in primary care had improved in recent years on the whole.

When asked if kidney health was a priority area of care:

- Many practice respondents (13/22) indicated that this is a priority area of care for them. 7 individuals cited this as a secondary concern. 2 interviewees suggested that kidney health was not a priority for them at all.
- At the executive level within the CCGs, most interviewees either saw CKD as a secondary priority within the broader agenda of holistic LTC management (5 of 13 CCGs) or not a priority at all (2 out of 13 CCGs). Only two CCGs indicated that CKD was a key priority area for them while AKI was identified as a key area by 5 CCGs.
- 2/23 CCG respondents identified other kidney issues as priorities (related to service integration and continuity of care at remote dialysis sites).
- There was a general desire to move towards 'combined care for LTCs/holistic approaches/CVD packages/vascular programmes' when describing approaches to the management of kidney health. In practices, this was often in the context of maximising efficient use of appointment time. Many CCG respondents who mentioned an aim or target related to CKD also suggested that CKD sat as a secondary element within the broader agenda of holistic LTC management, or indicated that there was another LTC(s) that took priority. The intent to move

towards holistic care is also reflected in the strategic plan of CCGs review compiled by CLAHRC GM in February 2015.

Other pertinent observations around the current state of kidney care were:

- Areas of kidney care where respondents had witnessed improvements included:
  - Increased prioritisation of CKD care in primary care;
  - CKD is much better monitored than it was when guidelines were first released;
  - Increased understanding of eGFR results amongst GPs, and how to act on them.
- CKD is well monitored in practice when it is associated with other LTCs such as diabetes.
- Despite improvements in recent years, kidney care was identified as an area where gaps in knowledge and skills still exist. The consequence of this would appear to be that clinicians are more comfortable managing CKD in combination with other vascular diseases as some of the aspects of care can be merged.

"One of the other big drivers is the knowledge and skills gap that resides within primary care around the management and identification of CKD...It's looked on as being very complicated...I think it's improved. It's better than it was. Part of the problem is that CKD is a relatively new diagnosis...compared to e.g. diabetes care there is a bit of lag." (CCG10)

3.1.2. Key drivers for kidney health priorities

After establishing what priorities interviewees identified for improving kidney health, we asked what the drivers were for selecting them. Interviewees could provide multiple drivers in response if applicable. There was some divergence here as we found that the agenda for practices was so strongly influenced by financial incentivisation, whereas other drivers were far more prominent for CCG interviewees. Therefore, the findings have been separated accordingly for this question.

3.1.2.1 Key drivers for practices

i) Financial incentives

- Unsurprisingly, the majority of practice interviewees (18/22) identified financial incentives as the dominant driver for directing kidney care in their surgeries. QOF was the most heavily cited (16) of these incentives. Localised incentive schemes accounted for the other two responses where remuneration was identified.
- CCG interviewees mentioned ongoing or planned local initiatives that may incentivise practices around improvements in kidney health:

- Salford CCG stakeholders highlighted that they had introduced a Locally Commissioned Service (LCS) for 2015/16 to financially reward practices to maintain the standards of care required by the retired QOF CKD indicators.
- North Manchester CCG indicated they were considering replicating the CKD LCS initiated by Salford CCG.
- Oldham CCG told us that although kidney health is not on their agenda for 2015/16, it would feature as a key part of their plans for 2016/17, and would be likely to involve some incentivisation for practices.
- Eastern Cheshire said that raising awareness of AKI was their immediate priority for kidney health, but that they are also planning some work to improve awareness and diagnosis of CKD later this year. The inclusion of a financial incentive was unknown at the time of the interview.

ii) Miscellaneous

There were no other strong themes that emerged as drivers for practices. Instead, a broad range of disparate drivers were recognised by practice interviewees, indicating the autonomous nature and heterogeneity of culture within general practice, as follows:

- Involvement in a previous CKD project with CLAHRC resulted in an eagerness to sustain improvements (4/22)
- Lower than expected recorded prevalence for CKD (3/22)
- The practice was aware that AKI was becoming more of a prominent issue on the local/national agenda (3/22)
- Awareness that complications or progression of poor kidney function can impact on other LTCs (2/22)
- A case study within the practice where avoidable AKI had been linked as a cause to a more serious incident (2/22)
- High nephrology referral rates or poor quality of referrals compared to other clinical areas (2/22 practices from two different CCGs)
- Having a personal interest in the discipline of kidney health (1/22).

3.1.2.2. Key drivers for CCGs

i) Locally driven

- Kidney health priorities were often generated by CCGs when local care was variable or poor compared to nationally published benchmarking data (16/23 respondents from 11/13 CCGs). The key clinical issues (highlighted by the benchmarking data) that prompted these decisions stemmed from 1) lower than expected recorded prevalence, 2) high referral rates and/or poor quality of nephrology referrals, and 3) suboptimal diagnosis of early stage kidney disease.
- Local leaders with personal or specialist interest in kidney care played an important role in promoting the issue.

- Interviews later in the consultation period with CCG members made reference to the GM Primary Care Standards (launched in June 2015), which were developed from mutually agreed priorities at GM level. CCGs will be able to pick areas of care to implement the standards for.

"Our CCG is certainly concerned that we are as an area over-referring into the renal clinic. They have clearly made the point that we as an area are over-referring." (PRA8)

ii) National policies/guidelines/trends

- 8/23 leads (from 7 of the 13 CCGs interviewed) suggested that the development of kidney priorities was linked to national kidney care policies (mentioned more so for AKI care rather than CKD). The new NICE AKI guidance, and particularly NHS England's 'Think Kidneys' programme, appear to have put AKI much more onto the agenda for primary care.
- The published data to support policies have highlighted the costs and mortality associated with AKI. The short-term savings that could be achieved through reducing the number/severity of cases are influential.
- There was also some awareness that support for practices would be required to implement recommendations in the updated NICE CKD guidelines.

iii) Lack of awareness/knowledge/confidence around kidney care

- 6/23 CCG interviewees also told us that the relative lack of awareness or confidence in managing kidney health affected decision making on priorities (5/13 CCGs).
- Specifically where CKD is concerned, rather than lack of awareness, interviewees suggested that the primary problem was the gap in confidence related to the difference in care regimes for different stages of the disease and managing complications.

3.1.3. Challenges identified

We asked all interviewees what they identified as the main challenges to implementing improvements in kidney care. Although we interviewed a similar number of CCG and practice based respondents, those in practice highlighted a far greater number of barriers.

i) Time/workload/capacity

Both CCGs and practices accepted that the current workload and time available in primary care was a significant challenge.

- Interviewees identified time and/or capacity as the primary factor (9/23 leads from 7 CCGs and 18/22 practices) significantly constraining practices' ability to implement improvements in kidney health.

- Some of those interviewed added that the appetite for additional initiatives is hindered by low morale. This was compounded, and in some part caused, by the feeling of being overworked/understaffed.
- Following on from this, CCG interviewees (8/23 from 7 CCGs) said that it was even difficult to get time with GPs to build initial engagement for potential interventions.

ii) Lack of awareness/knowledge/confidence around kidney care

- As noted in the driver section (3.1.2.2.) most common challenge mentioned (11/23 CCG leads from 6 CCGs, 10/22 GPs) was lack of knowledge and confidence around kidney care.
- The knowledge gap is emphasised by relative confidence when compared with other LTCs.
- There is still some dispute over the reality of CKD as a real disease state (as opposed to a natural aging process).
- Some specific examples of a clinical lack of understanding include:
    - Some struggled with classification of CKD (particularly in stages 3A & 3B) and lacked understanding of what to do with patients in each CKD stage.
    - They felt patient management guidance is not clear.
    - Patients are not being reviewed regularly, and that those on chronic anti-inflammatories are not being monitored and managed well enough in terms of kidney function.
    - Other CKD management problems stemmed from trying to get BP under control; which appropriate medication to use; and at what point should CKD patients be referred into secondary care.
- The inference was made by some respondents that a lack of understanding and confidence in managing CKD did influence some clinicians into a tendency to avoid the disease, especially in the absence of co-morbidities and treat it as a less important condition.

"...people just got to grasp with CKD, and accepted CKD as a real condition really, because I think lots of, especially traditional older doctors, didn't really think of it as a condition, I think they probably thought it was just a normal aging process..." (PRA3).

"Another thing that's worth mentioning is patient awareness. Time and time again we've found that patients have had on their notes 'chronic kidney disease' and they don't know it or when they become aware of it they say "What's that then?" and we can also be quite vague about it…so I think that's a big challenge, lack of awareness, partly on the doctor's side, but also on the side of the patients who do have it." (PRA22)

- 14/22 practice respondents suggested that issues related to patient awareness and compliance around kidney health presented a big challenge for them in management.

Some of the problems cited include: 1) the asymptomatic nature of CKD causes challenges when motivating the patient to comply with medication requirements/attend at reviews/return urine sample pots, and 2) patients don't understand CKD and there is a lack of suitable information available to them, which makes 'packaging the message' difficult without frightening them.

iii) Miscellaneous challenges

- 11/22 practice respondents suggested that their practice list size; associated administration problems and the national focus on patient access made management of kidney care more difficult to prioritise.
- 8/23 CCG leads, each from different CCGs, and 5/22 practice interviewees mentioned kidney health was less important than other areas.
- Other barriers for practices included:
    - The inefficiencies of not managing CKD in a holistic process (5)
    - Controlling high-BP or other complications associated with co-morbidities (4)
    - Managing referrals (2)
    - Service integration (e.g. laboratories) (2)
    - Language barriers with the patients was identified as a problem in one ethnically diverse area
    - Meeting targets (e.g. QOF)
- CCG interviewees provided several additional barriers, including:
    - Lack of a local champion for kidney health (4 leads from 3 CCGs)
    - Infrastructural problems for practices (patient access/IT systems) (3)
    - Service integration (3)
    - Patient compliance (1)
    - Managing referrals (1)

3.1.4. Effects of national policy changes on prioritisation of CKD care

We asked interviewees how the prioritisation of CKD care had been affected by recent national level changes to CKD guidelines and the QOF.

i) Update to the NICE CKD guidelines in July 2014

- There was a lack of awareness about the release of updated guidelines for CKD care in 2014:
    - 49% (12/22 practice respondents, and 10/23 CCG respondents – from 7 CCGs) said they were aware of the new guidance, but it would not prompt change at CCG/practice level respectively to existing care for CKD in the near future.
    - 38% (6/22 practice, 11/23 CCG) of interviewees were unaware that the guidelines had been updated in 2014.
    - 13% (4/22 in practices, and 2/13 CCGs) told us that they had begun to implement selected recommendations within the guidelines.

- For example, less than a quarter (3/13) of CCGs had initiated discussions about the potential of introducing CystatinC tests, recommended in the updated NICE guidelines, to help identify or exclude diagnoses of early-stage CKD.
- A few CCG members felt that as the guidelines affect the clinical management, it should be left to the clinical expertise of the GPs to decide whether and how to implement these changes in their practice.

ii) Changes to QOF CKD indicators in April 2015

- Awareness of the changes in the QOF contract was significantly higher than knowledge that updated guidelines had been released for CKD, which confirms the importance of QOF in leading practice-level priorities:

"I would say we are now pretty much governed by whatever your QOF targets would be." (PRA11)

- 49% of interviewees (10/22 GPs and 12/23 CCG respondents from 10 different CCGs) felt that the retirement of the majority of the QOF CKD indicators would have a negative impact on the standard of CKD care provided in primary care. Some interviewees suggested that the retirement had sent out the wrong message to practices about the clinical importance of CKD.
- 16 of the respondents (9/22 practice; 7/23 CCG – from 6 CCGs) felt that standards of CKD care would be maintained as the processes involved with ongoing monitoring are now well established in primary care, and/or that the important elements of CKD care would be covered by measures still on the QOF for other conditions. Some of this respondent group indicated that the basis for this sustainability was previous CKD intervention work delivered by CLAHRC GM that had improved confidence in managing CKD in their practices. Therefore, CKD patients with co-morbidities such as diabetes may continue to be diagnosed/managed more-or-less the same as previously, however there may be a higher risk of neglecting patients who have CKD without other LTCs.
- It was indicated that patients may still be offered tests, but it was noted they may not be chased up and encouraged as enthusiastically, as prompts will be removed from clinical systems. It is anticipated the level of commitment towards tackling CKD is likely to reduce.

"I imagine that if there isn't an incentive there to get their blood pressure to target, we won't treat them to target; if we're not incentivised to monitor their urine then that motivation to do that basic test will wither away, it will be submerged in all the other things you have to do for your patients every year." (PRA22)

3.2. Broader priorities

3.2.1. Priorities beyond kidney health

We asked interviewees what their broader priorities were for the forthcoming 12 months so that we could understand the contextual positioning of kidney health priorities compared to other issues. We received a broad range of responses to this question, even within a single CCG, so generic themes have been used to summarise. Please note that respondents most often indicated more than one priority.

- 14/23 CCG respondents (8/13 CCGs), and 12/22 practice respondents cited other disease areas outside of a CVD framework (such as mental health, cancer, dementia and sexual health) that were priority areas.
- 11/23 respondents referred primarily to holistic LTC care or an on-going programme of CVD improvement work over and above individual LTC management (7/13 CCGs).
- Other areas included:
    - Issues related to patient experience such as improving patient access, disease education, self-care (16/45).
    - Improvements in administration and planning, implementation of care plans, implementation of sick-day rules plans (some in relation to AKI, others associated with other conditions), preparation for CQC inspections (10/22) - mentioned by practices only.
    - Improvements in referral data (3/22) - mentioned by practices only.
    - 10/23 CCG interviewees from 9 different CCGs mentioned issues related to improvements for carers; end of life care; demand management; and service integration.

Each CCG is driven by its own strategic plans (a review of the five-year strategic plan for each CCG is embedded on this page). Multiple clinical areas within the integrated/holistic care framework were seen as high-priority, e.g. managing CVD within a wider programme of care – supported by both the interview data and the CCGs strategic plans. This was attributed by some respondents to the increase in the number of people living with multiple LTCs due to an increasingly aging population.

CCGs Kidney Health priorities.pdf

3.2.2. Key drivers for broader priorities

i) QOF and other financial incentives

- As discussed in the previous section, QOF is one of the most significant drivers behind any priority setting at the level of general practice.

- Other, singular responses discuss additional sources of funding utilised across different CCGs such as the Better Care Fund, Primary Care Development Plan, and Healthier Together Programme as past methods or future avenues for incentivising work within practice.

ii) Population health data

- 12/23 CCG interviewees (from 11 CCGs) told us that local data from practices; internal analysis or their Public Health teams played a key role in deciding what priorities were required to drive improvements.
- 5/23 CCG interviewees (from 4 CCGs) also mentioned national data in the decision-making process. However, this frequently meant data collected nationally but analysed locally, for instance, to highlight the gap between the estimated and recorded prevalence.
- Importance of the prevalence data was also reflected in the practice-level interviews (6/22).

iii) Clinical interests

- Within CCGs personal interest of staff can be a significant factor in driving priorities (6 out of 23 CCG respondents from 7 CCG).
- This has also been the case in some of the practices (4/22).

iv) Meeting quality targets

- Some CCG respondents explained how there would be a need for evidence that any sort of improvement strategy would be of benefit either to patient care or in terms of time, cost or efficiency before it could be implemented as a priority.
- Some practices stated that meeting the targets of the CQC inspections was a major driver.

v) Higher-level guidance

- 7/23 respondents each from different CCGs highlighted priorities that were driven by national agenda, so they 'had little choice' as a result.
- At a CCG level a frequent issue raised was that of the financial pressures to reduce costs (4/23).
- There is national guidance around reducing unplanned or unnecessary hospital admissions and this is reflected in the responses from interviews with CCG contacts. Almost a third of all the practices (7/22) mentioned the need to improve admissions and referral processes.

The factors above often acted in combination; it would appear that local opinion leaders push for policy developments and prioritisation based on their areas of speciality using their access to and interpretation of local data, which could be benchmarked against national

comparators. It is also important to note that for the majority of practices, their priorities are heavily influenced by what has been decided at the CCG level.

Non-executive GPs interviewees also completed a short questionnaire asking how the following factors influenced their priority setting for quality improvement (Table 2). These data confirm the strong influence of QOF and other incentivisation schemes, as well as local CCGs, in influencing the priorities.

Table 2. Influences on priority-setting within general practice

	Demands of QOF	*CCG programmes*	*Provision of Locally Commissioned Services*	*Other incentive payments*	*Personal interest of practice members*	*Response to audit*	*Pharmaceutical company incentive*	*Any other factors*
Very much so	*18 (82%)*	*14 (63%)*	*13 (59%)*	*11 (50%)*	*11 (50%)*	*9 (41%)*	*0*	*1 (5%)*
To some extent	*2 (9%)*	*6 (27%)*	*7 (32%)*	*9 (41%)*	*9 (41%)*	*11 (50%)*	*1 (5%)*	*2 (9%)*
Not at all	*2 (9%)*	*0*	*0*	*0*	*0*	*0*	*18 (82%)*	*2 (9%)*
Don't know	*0*	*2 (9%)*	*2 (9%)*	*2 (9%)*	*2 (9%)*	*2 (9%)*	*3 (14%)*	*17 (77%)*

3.2.3. Challenges to implementing broader priorities

To help us understand if the barriers to implementation of kidney priorities identified by interviewees were unique to that area of care or if they could be applied to all areas of quality improvement, we asked respondents to identify challenges (anticipated or experienced) in trying to implement their broader priorities.

The findings here are broadly comparable to those identified in implementing improvements in kidney health. In brief:

i) Challenges identified by the general practices:

- Time, money and capacity were mentioned by most practices (18/22). Four of these described staff turnover as an issue preventing engagement in project delivery.
- 5/22 cited issues related to patient behaviour and compliance in relation to; increasing disease awareness, preventing unnecessary A+E attendance, encouraging more self-management of conditions, and addressing non-attendance for appointments.
- Other challenges noted were; meeting individual needs of patients, meeting QOF/CQC targets for complicated patient groups, managing complications of co-morbidities, service integration, and engagement of colleagues in practice.

"I think our problems, because of the nature of where we are, are more to do with access. For example getting patients to come to our clinics." (PRA4)

ii) Challenges identified by the CCGs:

- Here, the CCG responses (17/23 from 11/13 CCGs) strongly correlated to the practice viewpoint that time, money and capacity were the key obstacles.
- 8/23 (from 6 different CCGs) told us that initial engagement/getting time with practice leads to discuss priorities and suggested interventions without supporting incentivisation schemes was one of the most difficult barriers.
- 7/23 respondents from 6 CCGs said there was a general lack of a QI culture (e.g. designing and testing improvements) within practices.
- 3/23 felt they had no problems with practice engagement.
- Other comments included; practice-to-practice variation/no single approach will work everywhere (3), integration of services was seen as an obstacle (1), IT systems not being well set-up to support improvement work (1), and issues around sustaining improvements (1).

3.3. What kind of support do people want?

In this section we report on the support that is *currently available*, and the support that CCGs and practices have expressed *they need*.

3.3.1. Current support

i) At the level of the general practices

We asked practices what would support them achieve their priorities for kidney health.

- 9/22 respondents indicated that their local CCG provided support, in terms of advice and guidance.
- 6/22 told us that no support was offered at all to help them.
- 5/22 cited the skills and knowledge of their colleagues within their practice.
- 4/22 respondents mentioned written guidelines or prompts on IT systems.
- 4/22 suggested other miscellaneous factors.

ii) At the level of CCGs

We asked CCGs what support they offered practices to help them improve performance around kidney care.

- 12/23 interviewees (from 9 different CCGs) said that the CCG provided support to practices via support teams to diagnose problems and suggest solutions; a triage service to manage the nephrology referral process and prevent unnecessary or poor quality referrals; or a GPwSI to provide guidance around priority development.
- Comparator data from within the CCG to design appropriate support (by identifying good practice and spreading learning) (6 from 6 CCGs).

- 4/23 (all from different CCGs) said that they request support from external organisations (e.g. CLAHRC GM; AQuA; HAELO).
- 4/13 CCGs said that outlier problems are discussed at local practice forums/meetings to brainstorm possible solutions amongst peer practices.
- Education sessions designed to address areas of weaker performance (4/23 across 3 different CCGs).
- Other support came from using external secondary care expertise and advice (2), or through bespoke IT/audit tools designed within or commissioned by the CCG (2).

3.3.2. Support needs identified by general practices

Practices were then asked what additional support would help them implement their priorities for kidney health, and for quality improvement in general.

Practices were not particularly clear about what support would help them and often demonstrated a lack of understanding about what support could be provided at a national level; at local level; and from external organisations such as CLAHRC (e.g. suggesting CLAHRC provides money for backfill of staff to make improvements).

i) Additional financial incentives or workforce resources

- 18/22 practices told us that additional improvements could be achieved through the provision of more money or resource to implement improvement work. This provision included a range of options such as; cash for the practice to employ additional staff or backfill time; local employment of a specialist nurse to be shared between practices; supply of external support (e.g. CLAHRC staff) to perform non-clinical project work in the practices.

" …(the challenge is) trying to fit it in with all the other demands on primary care. I think we are becoming very much the place where lots of work is being done and we're taking a lot of work from people and being utilised by hospitals to get things done because we're on the patients' doorstep and there's a great push to do more community, locally based services near where the patient is, but the problem is not all of it is funded...I do feel that we're just getting a bit saturated…" (PRA14)

"We always need support! I mean, it's just unfortunately there's more and more chronic disease management getting handed back to us, so our time for [treating] CKD is pressurised, as is our time for COPD or managing all the other chronic diseases we have to manage…" (PRA20)

ii) Education sessions or supporting material

- 9/22 practice interviewees from 9 of the 13 CCGs agreed that they could benefit from training events. Accessibility and suitability for training needs form two crucial factors

for attendance. Respondents stated a preference for events to be delivered by specialist GPs or consultants in the related area.

- 4/22 practices indicated that improved or simplified guidelines would support them in adoption of evidence-based care, as well as increased efforts to share successful processes across practices.
- 4/22 practice interviewees highlighted that improvements in the kidney care information available to patients would improve their capability to self-manage and improve outcomes.

iii) IT/audit tools

- 5/22 practices suggested that increased use of IT tools such as IMPAKT, GRASP-AF, and PRIMIS are needed to support patient identification, QOF objectives, and to guide improvement work.

"It comes back down to time, IT systems that can actually do something...anything that makes it easier…if we're going to do everything, something that pulls it all together and makes it more streamlined and more efficient…and even the updates for QOF…we're in a new QOF year but we probably won't get the new templates before September which means you're constantly backtracking…" (PRA7)

"...the sort of CLAHRC thing, obviously someone who can actually come and produce the audit, at least that's giving us the basis to then work from there, if you can be presented with the information and just that little bit of direction that actually makes things a lot easier..." (PRA7)

iv) Service integration

- Problems with information sharing and consistency across services were highlighted as areas where improvements would allow better care for kidney health. Suggested improvements related to better primary-secondary care referral discussions; clearer guidance for practices; triage services; improving phlebotomy services.

"Bolton has just set up an open access cardiology & respiratory consultant on call service, so we ring switchboard and say 'Can I speak with the cardiologist of the day?'...they're expecting our call so it's not a nuisance to them and we say 'This is the patient I've got, what do you want us to do?'…That's a same day service; it is followed up with an email with a confirmation of the contents of that conversation…(a similar service for CKD) would be handy..." (PRA08)

3.3.3. Support needed by CCGs for implementing kidney priorities

We asked CCGs what additional support or improvements would generate better outcomes for their kidney priorities.

- 14/23 respondents from 10 CCGs indicated that helping the CCG in achieving their priorities for kidney health would be the most welcome support. This could include providing education events for the CCG, or tailoring an intervention project with resources supporting CCG aims.
- 7/23 respondents suggested that helping CCGs to assess the current situation of kidney care so that they know the problems and knowledge gaps would be helpful (4/13 CCGs).
- 6/23 interviewees from 4 CCGs suggested that having an audit tool and/or IT prompts on practice systems would improve outcomes.
- Other suggested areas of support included:
    - More manpower/resources/money/time (9)
    - Simplified guidelines/protocols for practices (5)
    - Better service integration (5)
    - Producing better information for patients (1)
    - Raising awareness of problems amongst clinicians (1).

3.3.4. Support needed by CCGs for implementing broader priorities

We finished by asking specifically what organisations such as CLAHRC can do to provide support for implementing general improvement priorities in primary care as part of applied health research.

- 9/23 respondents told us that they would most value intervention projects or supporting education sessions that linked in with areas of priority that had been identified by their CCGs (6/13 CCGs).
- 6/23 respondents from 4 CCGs asked for things that would help bring research and practice closer together, such as providing access to the latest research evidence; suggesting solutions that are quick wins with financial impact; identifying clinicians who may want more involvement in research work; producing simplified versions of guidelines that are practically easier to use.
- 6/23 interviewees suggested that producing strong research data on which CCGs could base their decisions for priority setting would be important (4/13 CCGs).
- 5/23 interviewees told us that identifying local innovations and examples of good practice that had been effective; and then spreading them within other primary care settings would be more helpful than generating ‘another external intervention’.
- 4/23 respondents told us that providing evaluations of their existing and planned programmes of improvement work would be helpful (3/13 CCGs).
- Other suggestions included:
    - Proving the evidence-base and impact for research generated interventions prior to engagement (3)
    - Providing audit/data extraction/other IT support services (3)
    - Providing money for backfill to support improvement processes (2)

- Ensuring that sustainability is considered prior to any suggested intervention - *who* will sustain after the intervention, and *how* (2)
- Helping to improve patient engagement (1)
- Increasing profile and visibility so CCGs know what support is available (1).

"If you identify these patients, what's the trade-off for the CCG in terms of finances and things like that - and are those finances going to be put back to the practice and resource to manage those patients…the audit tool…that database stops AKI admissions…all those things need to be quantified, actually it has saved £25,000, here's the money, get a nurse in..." (CCG21)

3.3.5. Alignment with strategic plan review

Finally, we also undertook a review of the strategic plans for each CCG. On the whole these five-year plans reflected the responses during interviews. In interviews there was limited mention of specific GM-wide strategic reform plans such as; Healthier Together or the move towards federations. However, a common theme in interviews was the move towards a more holistic/integrated approach, to managing LTC conditions along with other comorbidities, and this aligned with CCG strategic plans/goals. Self-management, redefinition of care pathways, and care plans were significant elements of the strategic plans, but perhaps to a somewhat lesser extent in interviews.

Specifically around kidney health; half of the CCGs mentioned CKD in their five-year plans, tying in with the interview responses. AKI was not featured in most CCG's plans, although as mentioned previously, this may be demonstrative of its somewhat recent mounting attention. Despite this, AKI does fit in with better medicines management and reduction in emergency hospital admissions (which were noted heavily in plans), so still aligns with planned activity.

4. Limitations

Initially, five practices per CCG were selected to be approached. Following a poor response rate in this first wave, we trebled invites. Subsequently we used data published on practice websites to target GPs with a known interest in renal, LTC or CVD care. This approach resulted in many more interviews. In view of this, there is a bias in the personal interests of GPs interviewed, in addition to the planned targeting of LTC leads in CCGs. However, this did at least ensure 1) that we had a sufficient sample size, and 2) that those we interviewed were well informed about the subject matter and related ongoing work in their local area.

Unfortunately we were unsuccessful in gaining interviews with non-executive GPs in 2/13 CCGs despite repeated efforts. However we did succeed in getting interviews with CCG contacts in each of all 13 CCGs targeted.

The number of interviews conducted is a relatively small proportion of the number of practices across Greater Manchester and NHS Eastern Cheshire. However, as far as possible, we targeted a range of practice size and demographic to make our sample more robust.

5. Conclusions

- Awareness of changes and updates to the NICE guidelines, both in relation to kidney health and other areas, remains relatively low, especially at the level of general practices, with an additional delay in the guidance implementation associated with the time needed to bring the supporting services, electronic systems and templates up to date.
- Improvement interventions focusing solely on CKD are not likely to be met with enthusiasm unless there is a strong local interest championed by clinical leads and local incentivisation programmes are in place to support this work.
- Although there is a growing interest/awareness in AKI in some of the CCGs, and AKI reduction is seen by some as a way of policy-mandated decrease in hospital admissions, the data indicate a relatively low awareness of this condition as well as of recent AKI-related policies amongst GPs.
- Overall, there is a significant diversity across different CCG areas in relation to the priorities identified, and no single improvement intervention is likely to suit the needs of all CCGs and/or practices.
- Programmes of work that reframe kidney health interventions as part of integrated/holistic approaches to cardiovascular diseases or long-term-conditions in general are more likely to be taken up by local commissioners, especially if these proposed interventions are explicitly linked to the strategic improvement programmes currently undertaken by the CCG.
- The QOF and other financial incentives remain the key driver for priority setting, particularly for non-executive GPs, with other important drivers including: the clinical interests of key stakeholders; benchmarking of CCGs and general practices against quality targets; population health data; and national priorities (particularly, reducing hospital admissions and cutting costs).
- A broad range of needs was identified in relation to future improvement work:
    - Provision of resources (e.g. funding for additional staff or tools)
    - Supporting the implementation and evaluation of locally designed improvement programmes (especially outcome evaluations)
    - Education and training (around various aspects of kidney health, NICE guideline updates and quality improvement in general)
    - IT support (extracting data to support them in achieving QOF objectives and reducing variation where it is identified; populating multiple templates; identifying and managing patients; updating IT systems in the light of the new QOF and NICE guidelines)
    - Achieving better integration with secondary care and other supporting services (e.g. phlebotomy; laboratories).
- Many of the CCGs already have complex programmes of improvement work underway, and they felt that they would favour the involvement of organisations in

supporting this work over participation in new interventions designed by other organisations.

- The priority setting process tends to focus on short-term goals rather than long-term impact or sustainability of change, with many organisations particularly interested in 'quick fixes' that would enable measurable improvement in financial and/or clinical performance.
- Improvement interventions are more likely to be prioritised by commissioners if they are:
    - Aligned with the QOF or local incentivisation programmes;
    - Driven by local clinical champions;
    - Supported by data demonstrating their relatively quick impact on performance or patient care outcomes;
    - Seen as relevant for local populations;
    - Linked with existing strategic plans adopted by the CCGs.

Appendix A. Interviews by location

CCG contacts

	Initial contact made	Contacts engaged/replied	Interviews completed
NHS Bolton CCG	6	4	2
NHS Bury CCG	6	4	2
NHS Central Manchester CCG	4	1	1
NHS Eastern Cheshire CCG	3	2	1
NHS Heywood, Middleton and Rochdale CCG	5	1	1
NHS North Manchester CCG	8	8	3
NHS Oldham CCG	3	3	3
NHS Salford CCG	7	6	4
NHS South Manchester CCG	3	1	1
NHS Stockport CCG	6	3	1
NHS Tameside & Glossop CCG	6	3	2
NHS Trafford CCG	3	1	1
NHS Wigan CCG	5	3	1
Totals	65	40	23
		Yield of responses from initial contacts	**Yield of interviews from initial contacts**
		62%	35%

Practice contacts

	Initial contact made	Contact engaged/replied	Interviews completed
NHS Bolton CCG	11	7	2
NHS Bury CCG	11	7	3
NHS Central Manchester CCG	12	9	3
NHS Eastern Cheshire CCG	12	9	1
NHS Heywood, Middleton and Rochdale CCG	11	4	2
NHS North Manchester CCG	14	8	3
NHS Oldham CCG	16	3	0
NHS Salford CCG	13	8	2
NHS South Manchester CCG	15	6	1
NHS Stockport CCG	12	5	2
NHS Tameside & Glossop CCG	10	8	0
NHS Trafford CCG	12	6	1
NHS Wigan CCG	7	2	2
Totals	156	82	22
		Yield of responses from initial contacts	**Yield of interviews from initial contacts**
		53%	14%

Combined

	Initial contact made	Contact engaged/replied	Interviews completed	% yield
NHS Bolton CCG	17	11	4	24%
NHS Bury CCG	17	11	5	29%
NHS Central Manchester CCG	16	10	4	25%
NHS Eastern Cheshire CCG	15	11	2	13%
NHS Heywood, Middleton and Rochdale CCG	16	5	3	19%
NHS North Manchester CCG	22	16	6	27%
NHS Oldham CCG	19	6	3	16%
NHS Salford CCG	20	14	6	30%
NHS South Manchester CCG	18	7	2	11%
NHS Stockport CCG	18	8	3	17%
NHS Tameside & Glossop CCG	16	11	2	13%
NHS Trafford CCG	15	7	2	13%
NHS Wigan CCG	12	5	3	25%
Totals	221	122	45	
		Yield of responses from initial contacts	**Yield of interviews from initial contacts**	
		55%	20%	

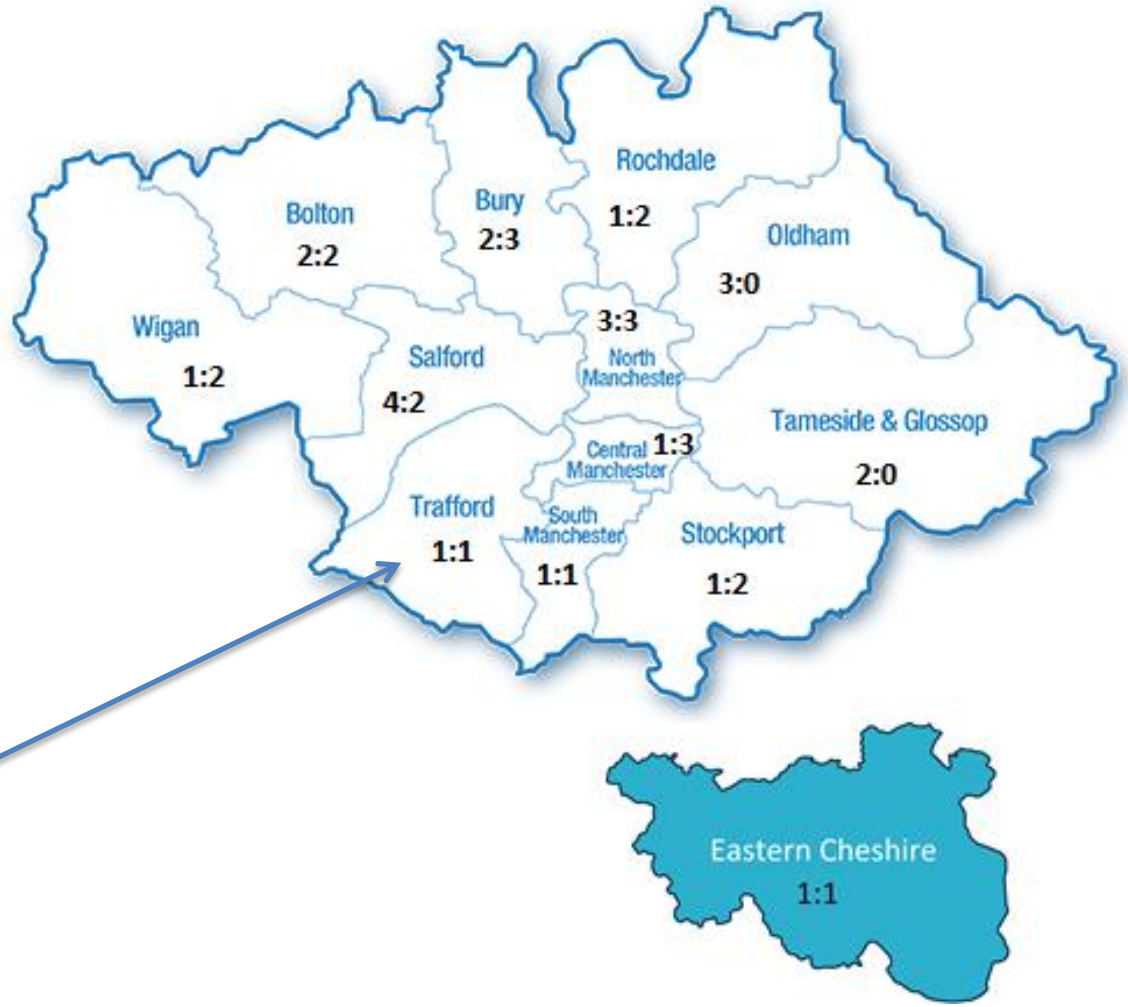
Appendix B. Map of data sample

We interviewed:

- 23 CCG leads (12 of whom were also practicing GPs)
- 22 GPs (who did not also hold an executive role within their local CCG)

To achieve this, we contacted:

- 65 CCG contacts
- 156 contacts within GP practices



Key to image:
No. of CCG interviews **n:n** No. of GP interviews

Appendix C. Interview questions

CCG interview questions

i) Name of CCG
ii) Staff name
iii) Staff role

1. a) What are your specific priorities relating to CKD/kidney health in primary care?
   b) If priorities are identified: what were the drivers for developing these?
2. How have your priorities regarding kidney health changed since the updated NICE CKD guidelines were released in summer 2014?
3. Will they change with the removal of CKD indicators from QOF in April 2015?
4. Are there any enhanced service payments associated with this area of work - e.g. Directed Enhanced Service (DES) or Locally Commissioned Service (LCS) payments?
5. Do you have any other interventions relating to CKD/kidney health planned for primary care?
6. What issues have you encountered when working with your local practices specifically on CKD kidney health?
7. What support is available to improve performance where problems are identified?
8. What kind of support do you think would be useful in improving CKD/kidney health across the CCG?
9. How do you measure the impact of those interventions in relation to kidney health?
10. What quality improvements priorities do you have in the next year?
11. How were these priorities decided?
12. How do they relate to your kidney priorities?
13. What issues have you encountered when working with your local practices on quality improvement programmes in general?
14. How can CLAHRC help to support the implementation of these quality improvement priorities?
15. Any additional comments?
16. Do you know of anyone else it would be beneficial to contact?

Practice interview questions

i) CCG based within
ii) Practice name
iii) Staff name
iv) Staff role

1. a) What are specific priorities relating to CKD/kidney health?
   b) If priorities are identified: what were the drivers for developing these?
2. What challenges do you face in meeting these priorities (e.g. workload, staff capability etc.)
3. Is there anything that supports you in this work?
4. What additional help or support would enable you to carry out this work more effectively?
5. The QOF indicators (relating to CKD) have changed significantly for the next year. What do you think of the change?
6. The NICE CKD guidelines were also updated in summer 2014. How has this changed CKD care in your practice?
7. Do you plan to change your management in any way now that the targets and guidelines are changing?
8. What help or support would enable you to carry out any changes in management of CKD more effectively?
9. What quality improvement priorities do you have in your practice in the next year?
10. How were these decided?
11. What are the challenges for you in doing this work?
12. How can CLAHRC help support the implementation of your quality improvement priorities?
13. In general, to what extent do these things influence your priority setting for quality improvement?

(Please mark one oval per question)	Very much so	To some extent	Not at all	Don't know
CCG programme	▢	▢	▢	▢
Demands of QOF	▢	▢	▢	▢
Other incentive payments	▢	▢	▢	▢
Provision of locally commissioned services	▢	▢	▢	▢

Personal interest of practice member(s)	▢	▢	▢	▢
Response to audit	▢	▢	▢	▢
Pharmaceutical company initiative	▢	▢	▢	▢
Any other factors	▢	▢	▢	▢

14. Do you have any additional contacts who you can suggest for this consultation exercise?