Improving Care for People at Increased Risk of Cardiovascular Disease: Co-designing a Way Forward

Following on from individual meetings with local Clinical Commissioning Group (CCG) leads, an event (hosted jointly by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Greater Manchester (NIHR CLAHRC GM) and the Greater Manchester Academic Health Science Network (GM AHSN) was held to bring together key stakeholders from across the Greater Manchester and Eastern Cheshire (GM) region. This provided a forum to collectively identify GM-wide priorities around kidney health/Cardiovascular Disease (CVD) at-risk groups, encouraged networking between those with similar clinical interests, and enabled the sharing of good practice and ideas that might be suitable for further spread. In this document we summarise the feedback from this event.

Why does kidney health matter?

Kidney health is important in the context of other long-term conditions - whilst there was discussion about whether chronic kidney disease (CKD) should be classed as a disease at all (with some viewing it as overdiagnosed) there was general consensus that CKD had many commonalities with other long-term conditions and was a risk factor for CVD. As such, care should occur within wider long-term condition management, but with recognition of the unique needs of the different conditions. It was recognised that there is a need to establish priorities of an individual's care where there are multiple long-term conditions but with minimum expected standards being set.

A priority area is to focus resources on those at risk of decline in renal function - some thought that detecting and treating those at high risk of decline should be the priority, with investment where there is evidence of the best return for patients. There was a general consensus that there needs to be improvements in the availability of real time data and tools to track kidney function, particularly for those with proteinuria who were considered most at risk of decline.

There are opportunities for prevention and early diagnosis - prevention of CKD within a wider public health message about improved lifestyles was viewed as important, as was prevention of decline in renal function for those with a diagnosis of CKD 3a. This could be aided by centralised case finding, primary care prevention teams, evidence-based strategies for lifestyle changes and raising health aspirations across GM with consistent messages

This work is funded by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Greater Manchester. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

about how patients can improve their own health. Better use of health checks was also suggested as a way to improve uptake of basic tests, as was a more flexible use of the health and social care workforce to extend opportunities for screening and monitoring.

There are opportunities for improving education and raising awareness - amongst the general public and for individual patients at diagnosis of CKD or a related long-term condition. There was also recognition that healthcare professionals needed education and support to interpret and implement kidney health guidelines, to be able to give combined messages across multiple morbidity and develop effective patient management plans.

What are the challenges of implementing change in primary care?

There is a lack of incentive to change - whether these be lack of financial incentives or poor understanding/knowledge or interest about specific disease areas and related guidance. The incentives need to include the whole team not just a few enthusiastic individuals, and the benefits need to be effectively sold.

There is no additional capacity for change - there are already too many other requirements during clinic appointments, and other changes taking place. Demand is outstripping capacity which leaves no time for strategic long-term planning. There is a clear tension between the need/enthusiasm to make improvements and the battle for capacity and other priorities.

Lack of ability to share and link real time data - it's difficult to share information easily and rapidly between primary and secondary care, and there is poor access to real time data.

Ineffective systems - the model of 1:1 GP/practice nurse/patient communication is ineffective at bringing about wide scale change. Incentivising disease management allows basic care to be left behind and there is limited focus on patient self-management of long-term conditions, particularly in the case of kidney health which is rarely discussed with patients. There was also some concern about creating the ‘worried well’.

What opportunities are there to address these challenges ?

Upskill the workforce - improved information for GPs/practice nurses and other workforces on how to change things.

Link to GM wide changes - any future plans should be linked in with the Greater Manchester Health and Social Care Partnership.

Improved support tools - to aid decision making and link data more effectively. Benchmarking against other practices also seen as helpful.

Simple solutions - simple, easily implemented changes with clear emphasis on the benefits are more likely to be successful.

Sharing of ideas that may help improve kidney health

There were five key areas that were identified as potential enablers in making improvements in primary care:

1. Standards and local incentives.
2. Developing workforce capacity.
3. Utilisation of clinical data/IT.
4. Sharing knowledge/increasing awareness.
5. Support around the utilisation of guidance.

1. Standards and local incentives - should avoid tick box approach used by the Quality and Outcomes Framework (QOF) and engage with GPs to develop local incentives that will focus on improving care in needed areas. Incentives need to be accredited in a meaningful way, however there is recognition that incentives alone are not effective, particularly in low performing practices. Whilst incentives help the change they don't *make* the change - changes are made by well meaning and well educated individuals with the motivation and time to bring about changes. There needs to be more support for lower achieving practices and more open sharing of information between practices to create healthy competition between neighbourhoods of practices. A better way of doing patient-centred care that is amenable to practices would be useful.

2. Developing workforce capacity - a more flexible workforce and better utilisation of aligned workforces to shift activity from GPs/practice nurses would be beneficial, with better use of healthcare assistants to support lifestyle changes and practice-based pharmacists who could add capacity potentially via medication reviews, case-finding and management. Community pharmacists or other community organisations could also be used for some related activity, improving access to patients, and GP receptionists could aid referral to the appropriate workforce. An e-clinic model or virtual clinics may also be beneficial for the care of acute kidney injury (AKI) to enable quick and easy access to specialist advice.

3. Use of clinical data/IT infrastructure - improvements in data for practices and patients were seen as two key areas. GP practices need better access to real time audit results, flags of high risk patients that require improvement in elements of their care, as well as investment in business intelligence to improve primary and secondary care communication without the requirement for the patient to visit hospital based clinics. The challenge faced here is multiple systems in place (e.g. EMIS, Vision, Datawell, Graphnet, Orion, FARSITE) would need access to GM-wide data. The ability for patients to self-manage and self report their long-term conditions via apps and portals, and to also receive data about what care to expect, remind them of upcoming review appointments, and give them responsibility for following up blood results is a growing and potentially useful area to develop, but would be need to be based on evidence of effectiveness.

4. Sharing knowledge and increasing awareness - communication is key across all aspects of pathways - professional to professionals, and professional to patient. There is a need to increase awareness and understanding of kidney health conditions with better communication across pathways of care, and support and education freely available to all. Alternative avenues for delivering patient education outside of consultations should be explored, with an emphasis on early intervention and designed to cut across long-term conditions risks.

5. Support around utilisation of guidance - better performing practices are more likely to be responsive to guidelines, but poorer performers need more support to implement changes in guidance. The use of real time data and prompts was seen as useful to support the utilisation of guidance but this needs to be combined with regular/real time measurement of improvements so that practices can see their improvements and have ownership.

Feedback

The feedback we obtained from the evaluation forms (73% of the delegates completed an evaluation form) tells us that everyone felt involved in the discussion and nearly everyone felt the event was productive for GM as a whole. Between 90% and 95% of delegates agreed that we met the desired objectives of understanding of how we are doing in relation to the management of CKD; discussing how much kidney health matters; identifying the key challenges of change and sharing ideas that might help. 73% to 89% of delegates agreed we have a way forward to drive change across GM. In the words of one of the delegates:

"The ground work, however, has been laid and lots of ideas generated as well as an understanding of challenge. Really looking forward to seeing this take shape"

Next steps

Moving forward the NIHR CLAHRC GM and GM AHSN will explore some of the options discussed during the event. We will continue to work with all the CCGs aligning with other ongoing work and future plans and further shape plans for improvements in care for those at high risk of CVD.

More information

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