

CCG Factsheet

Moderate to severe chronic kidney disease (CKD) affects approximately 5% of adults in the UK. It is often found in older people and in people who suffer from diabetes and/or high blood pressure. CKD is known to be associated with an increased risk of death, cardiovascular events, and hospitalisation as well as predispose people to acute kidney injury. Asymptomatic until later stages of the disease, CKD is detected using blood and urine tests. Most people with CKD are identified and managed by their general practitioner who is then able to use a number of computerised (Read) codes in the practice computer systems to identify these patients.

The National CKD Audit was commissioned in England and Wales to review the testing, identification and management of those with CKD in primary care, as well as their health outcomes. Primary care management includes regular monitoring of kidney function and blood pressure, avoidance of treatment that may further damage kidneys, and taking appropriate steps to protect general health. The purpose of the Audit was to provide a snapshot of performance in primary care against NICE guidelines and quality standards. The key findings and the recommendations as a result of these findings are presented below:

1. For people at high risk of CKD GPs should ensure they include BOTH blood tests for eGFR and urine testing for albumin to creatinine ratio.
 - Accurate diagnosis and disease stratification requires both blood and urine tests, with Evidence of an eGFR less than 60 ml/min/1.73m² on two occasions at least 90 days apart.
2. GPs should review the procedures in place to identify patients who have evidence of CKD.
 - Uncoded CKD ranges from 0% to 80% indicating wide variation in practice performance.
 - There is good evidence that coding is associated with improved performance in key areas of CKD management.
 - The linked GP-hospital data in this audit provides preliminary evidence that people with uncoded CKD have higher rates of unplanned admissions and death.
3. CCGs/LHBs should consider putting in place quality improvement tools and incentives in order to support the identification and regular clinical review of patients with CKD.
 - With the retirement of CKD indicators from the quality and outcome framework, CCGs/LHBs need to ensure that local indicators for CKD identification, coding and management are in place.
 - This should improve the care for people with CKD, and is likely to contribute to reductions in hospital admissions.
4. Having identified people with CKD, effort should be focussed on regular review including management of high blood pressure, prescribing cholesterol lowering treatments, and advising flu and pneumococcal vaccination to improve health outcomes.
 - Among people most likely to develop progressive CKD (people with diabetes or urinary albumin/creatinine values >70mg/mmol), 70% had blood pressure values above the target range.
5. Further research is needed to establish whether there is a causal link between CKD coding as a proxy for clinical awareness of CKD and hospital admissions/death.

More detail can be found here <https://www.lshtm.ac.uk/ckdaudit>