



NHS High Weald Lewes Havens CCG

Background

This cardiovascular disease summary profile focuses on kidney disease and is produced by the National Cardiovascular Intelligence Network (NCVIN). The profiles are available for each clinical commissioning group (CCG) in England on coronary heart disease and heart failure, diabetes, kidney disease and stroke. This profile compares the CCG with data for England, a group of similar CCGs and the Sussex and East Surrey Sustainability Transformation Partnership (STP).

Key Facts	CCG	Similar CCGs	STP	England
Observed prevalence of CKD (per cent)	4.5	5.5	4.6	4.1
Estimated prevalence of CKD (per cent)	7.3	-	7.1	6.1
Patients diagnosed with CKD whom the last blood pressure reading is 140/85 or less (per cent) (2014/15 QOF)	71.5	75.5	72.2	74.4
Number of people receiving RRT	143	-	1,578	52,953
Proportion of people receiving RRT with transplants	50.3	-	51.7	53.6
The acceptance rate onto RRT	105.3	-	107.4	111.2

Key Information

In 2017/18 There were 6,112 people aged 18 years and over who had been diagnosed with chronic kidney disease (CKD) in NHS High Weald Lewes Havens CCG. This represents 4.5% of the registered population aged 18 or over.

The primary care CKD clinical indicators were removed from QOF in 2015/16. This information is still being collected from some GP practices.

The acceptance rate onto Renal Replacement Therapy (RRT) in 2011 to 2016 for NHS High Weald Lewes Havens CCG is 105.3 per million population compared to the England rate of 111.2.

There were 143 NHS High Weald Lewes Havens CCG residents receiving RRT in 2016. The change in the number of residents receiving RRT between 2011 and 2016 was 44.4%.

In NHS High Weald Lewes Havens CCG during 2016 the percentage of people receiving RRT who had a renal transplant was 50.3%, a further 9.8% received home dialysis and 39.9% received hospital dialysis.

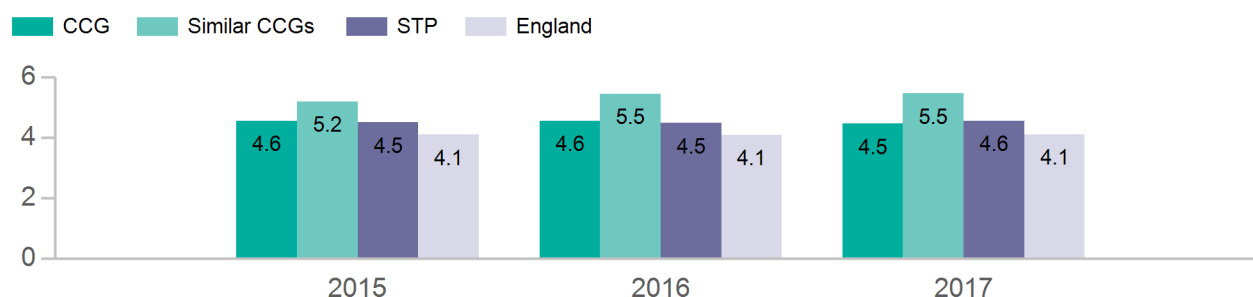


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Disease prevalence

Prevalence is the number of people in a given population with a particular condition at a point in time. CKD is classified into six stages based on glomerular filtration rate (roughly a percentage of kidney function) and three levels of proteinuria (protein in the urine). This profile describes the prevalence and management of moderate to severe CKD (i.e. CKD stages G3–G5 as defined by the NICE). Stage 3 CKD can be sub classified into 3a and 3b with stage 3b experiencing a higher risk of CVD and end stage renal disease (ESRD) than those in 3a.

Chronic kidney disease prevalence, 2015/16 - 2017/18 (per cent)



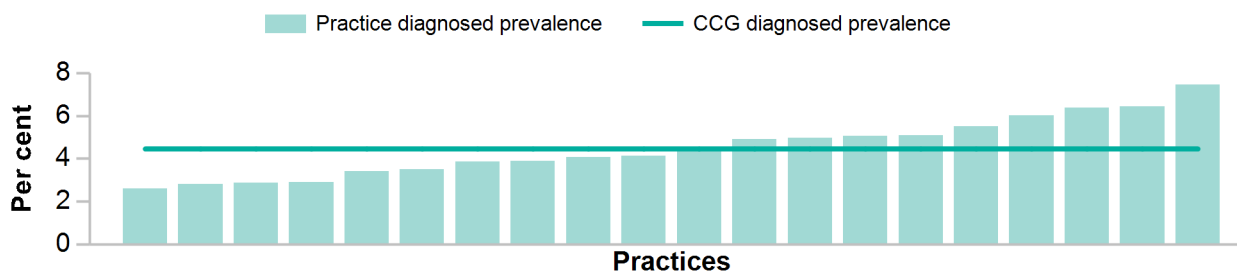
Source: Quality and Outcomes Framework (QOF), 2017/18 Copyright © 2019, Re-used with the permission of NHS Digital. All rights reserved.

Patients diagnosed with CKD benefit from early treatment which can reduce mortality and slow progressive decline in kidney function. Diagnosis also highlights patients at risk of greater harm due to medication side effects and acute kidney injury.

The diagnosed (observed) CKD prevalence in NHS High Weald Lewes Havens CCG is 4.5%. The estimate of total levels of CKD (diagnosed and undiagnosed) in the population is 7.3%. In England the estimated prevalence of CKD varies by gender with an estimated prevalence of 4.7% in men and 7.4% in women. Prevalence increases with age, and in people aged 64 and under the estimated prevalence is 1.9%, increasing to 32.7% in people aged 75 and over.

Source: Prevalence estimates, 2011 CKD Prevalence model, G.Aitken, University of Southampton based on the Health Survey for England 2009 and 2010

Variation by general practice of chronic kidney disease prevalence, 2017/18 (per cent)



Practice level prevalence values with the practice identified can be found at <https://fingertips.phe.org.uk/profile/cardiovascular>

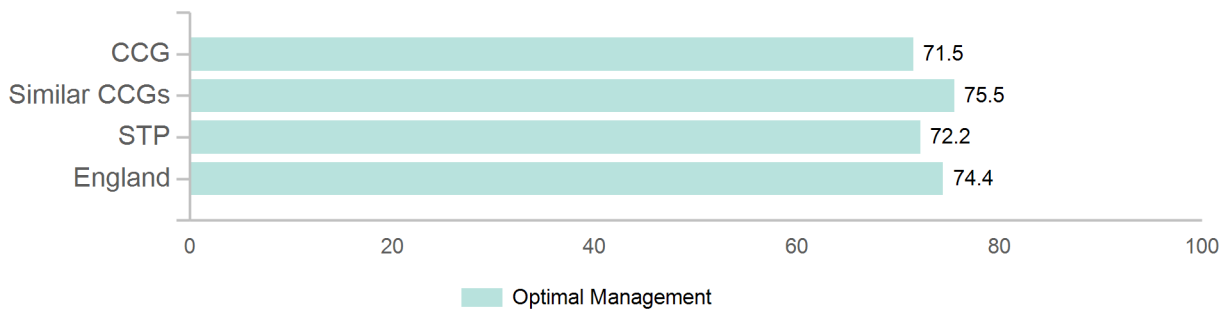


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Care processes and treatment indicators

In 2014/15 there were three QOF CKD treatment indicators which described the management of CKD in primary care. The graph below shows the achievement of CKD002 in 2014/15, the last year when the indicator was a mandated or incentivised QOF indicator.

The percentage of patients on the CKD register in whom the last blood pressure reading is 140/85 mmHg or less, CKD002, 2014/15 (per cent)



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From April 2015 the management of patients on the CKD register is no-longer contained in the QOF, but treatment of hypertension remains the single most important means to decrease overall cardiovascular risk in CKD, and to reduce the chance of progression to ESRD. In 2017/18 data on blood pressure readings in people on the CKD register was still submitted from approximately 78% of GP practices across England. For practices submitting data in England in 2017/18 the percentage of patients with CKD who achieved the BP management target in the preceding 12 months was 65.5%. As the CKD indicators are no longer in QOF, there is a different data collection mechanism now in place, this means that the 2014/15 and 2017/18 treatment figures are not directly comparable. Information on the CKD indicators and other indicators no longer in QOF can be accessed on the NHS Digital website <https://bit.ly/2QuoGzQ>

Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) is the preferred term for acute renal failure. It is a condition where there is a rapid reduction in kidney function over hours or days. It is estimated that in the UK up to 100,000 deaths each year in hospital are associated with AKI. Think Kidneys is a national programme led by the renal community and supported by NHS England and the UK Renal Registry and is the NHS campaign to improve the care of people at risk of, or with AKI.

Biochemistry laboratories have been mandated since April 2015 to submit data on AKI to the UK Renal Registry. Over the twelve months (July 2017 - June 2018) in England there were 448,000 AKI alerts reported to the UK Renal Registry. Using all the AKI alerts submitted in the 12 month period the overall age and sex adjusted thirty-day mortality for people with AKI was 17% this was higher with increased AKI stage. Rates of AKI are reported on a quarterly basis and sent by the UK renal registry to all England CCGs.

For further details see the Think Kidneys website www.thinkkidneys.nhs.uk/aki/aki-data/



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Preparation for Renal Replacement Therapy (RRT)

It is clinically advantageous for people with ESRD to be referred to kidney services early to allow consideration of treatment options and for complications such as anaemia to be managed. Renal Association guidelines recommend a minimum of 90 days preparation time, in practice longer is often needed for sometimes complicated decision making. There is no national collection of data on patients with advanced CKD not receiving RRT (although this is now beginning). The measures presented below indicate the number of people who begin RRT in the given time period, they do not measure people who do not receive RRT and who opt for supportive care (sometimes called “conservative kidney care” or “conservative management”). This important group of people choosing not to have RRT are often complex to care for well as they are commonly frail, and have multiple other medical problems. For some CCGs the number of patients is low or the data incomplete, so the data has been suppressed.

Provision of services, 2011 to 2016

	CCG	England	STP
RRT acceptance rate (per million population), 2011 to 2016	105.3	111.2	107.4
Ratio of observed / expected number of people accepted onto RRT, 2011 to 2016	0.8	1.0	0.9

Source: UKRR, 2016

Acceptance rates reflect the number of patients commencing RRT. Acceptance and prevalence rates vary between different CCGs. This is due to a number of different reasons reflecting the demography of the local population and demand for and supply of RRT services within local areas. The number of people who opt not to have RRT (currently not measured nationally) is another important reason for variation in RRT acceptance rates.

The Transforming Participation in Chronic Kidney Disease (CKD) programme

NHS England and the UK Renal Registry are undertaking a programme to ensure that people with kidney disease are placed at the centre of their own care. This programme is called the Transforming Participation in Chronic Kidney Disease (CKD) programme and details can be found on the Think Kidneys website.

An online service called Patientview is available for people with kidney disease (and in some areas inflammatory bowel disease and diabetes mellitus). Patientview lets people monitor their results, manage their condition and communicate with their care team. The system is now available in more than 90% of UK renal units. More details about Patientview can be found at www.patientview.org.

Patient reported outcomes

In 2016 the UK Renal Registry in conjunction with the British Kidney Patient Association circulated a Patient Reported Experience Measure to the 52 renal units in England. 8,800 surveys were returned from 41 centres. More details are available from www.thinkkidneys.nhs.uk/ckd



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End stage renal disease (ESRD)

This section summarises some indicators of service use and the care delivered to the CCG by kidney centres. The data is taken from the UK Renal Registry (UKRR). People within the CCG may attend different kidney centres and these and other indicators are available at kidney centre level from the UKRR website www.renalreg.org. Variability between these kidney centre indicators can reflect different patterns of service provision, for example, transplant centres or differences in the populations or the geographical areas served by the centres. Data should be interpreted with local knowledge in mind. Nationally the number of people receiving RRT continues to rise despite little change in the number of new people starting RRT. This is generally explained by a gradual national decline in mortality which is no different between centres once adjusted for case-mix.

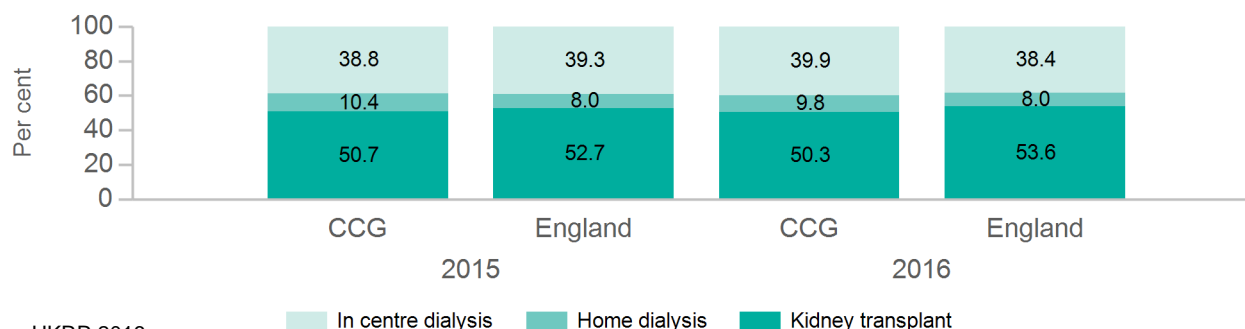
Provision of services, 2011 to 2016

	CCG	England	STP
Number of people receiving RRT, 2016	143	52,953	1,578
Change in number of people receiving RRT, 2011 to 2016 (per cent)	44.4	19.9	25.2
Proportion of dialysis patients receiving home dialysis (home HD and PD combined) (per cent), 2016	19.7	17.3	20.6

Proportion of people on RRT by treatment modality

Although a person's initial choice of the type of RRT is important – so is the availability of the range of treatment choices (including home therapies and renal transplantation) to those already receiving RRT. Supporting patients doing home therapies in particular is crucial if they are to continue with the treatment long-term. The proportions of people having each type of treatment, gives an broad indication of ongoing access to choice, and also patient support to remain independent.

RRT by treatment modality type (transplant, hospital dialysis, home dialysis) 2015 to 2016 (per cent)



Source: UKRR 2016

The interpretation and reporting of these data are the responsibility of NCVIN and should not be seen as an official policy or interpretation of the UKRR or Renal Association.

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